

The Effectiveness of the Small Employer Health Insurance Availability Act in Promoting Rate Stability, Product Availability, and Coverage Affordability

December, 2006

Hlnckley, Allen & Tringale, LP

DeWeese Consulting, Inc.

Table of Contents

	PAGE
Executive Summary	1
Introduction.....	1
Regulatory Objectives	2
Finding 1: Total Enrollment Has Decreased	2
Finding 2: Average Group Size is Smaller at BCBSRI.....	3
Finding 3: More Attention Needed to Managing Groups of One Subscriber	3
Finding 4: Product Portfolio	4
Product Finding A: Product Portfolio is Cumbersome and Complex; Streamline and Improve Education Efforts.....	4
Product Finding B: United's popular plans have more cost- sharing than those of BCBSRI	6
Finding 5: Finances	6
Finance Finding A: BCBSRI Has a Higher Percentage of Members with High Cost Claims	6
Finance Finding B: United Has Higher Profit Ratios.....	7
Finance Finding C: Carriers Differ Greatly in the Magnitude of Producer Bonus Payments	8
Finance Finding D: <u>Recommendations</u> for the Small Group Health Insurance Distribution System	8
Finding 6: Carriers' Evaluation of Members' Health Status Moving in Opposite Directions	9
Finding 7: Current Rating Requirements are Consistent with Legislative Goals	10
Finding 8: Consider Additional Protections to Ensure More Even Risk Distribution.....	11
Finding 9: Producers Supportive of Product Streamlining, Cost-sharing and Transparency to Clients.....	12
Finding 10: Affordable Health Insurance Requires More Than Cost Shifts.....	13
Conclusion.....	14
Key Recommendations	15
Introduction	19
The Purposes of the Act	22
Elements of the Act.....	23
A. Eligibility	23

**The Effectiveness of the Small Employer Health Insurance Availability Act in Promoting Rate Stability,
Product Availability, and Coverage Affordability**

B. Product Availability	24
C. Rating.....	24
D. Renewal Requirements.....	26
Findings—an Overview of the Market	28
A. Small Employer Enrollment	28
B. Group Size	32
C. Benefit Plan or Product Mix.....	38
D. The Components of a Health Insurance Rate	43
1. Claims Expense	44
2. Loss Ratio	46
3. Administrative Expenses and Contribution to Reserves.....	48
4. Distribution Systems and Costs.....	49
E. Demographics—Age/Gender and Health Status.....	57
Carrier-Specific Compliance Issues	64
A. BCBSRI.....	64
B. United.....	65
Producer Survey Results.....	67
Overall Issues of Concern and Resulting Policy Recommendations	72
A. Managing Groups by Size, Particularly Groups of One Subscriber.....	77
1. Segmenting the Small Employer Pool by Size	77
2. Treatment of Groups of One Subscriber	80
B. Product Portfolio.....	92
1. Eliminate the requirement to sell the two statutory plans	93
2. Permit Streamlined Portfolios.....	94
3. Encourage Joint Education Efforts	95
C. Distribution System	97
1. Payment of Commissions.....	98
2. Volume or persistency-based bonuses	101
3. Marketing	102
D. Rating Requirements	103
1. Rating by Industry or Size of Group	104
2. Health Status Adjustment.....	105
3. 4:1 Compression	107
4. List billing	110
E. Additional Protections for More Even Risk Distribution	111
1. Reinsurance or Risk-Adjustment:	111
2. Administrative Services Only (ASO) Plans.....	113

**The Effectiveness of the Small Employer Health Insurance Availability Act in Promoting Rate Stability,
Product Availability, and Coverage Affordability**

3. Rate Review	114
4. Minimum Loss Ratio Requirement	115
5. Minimum Participation Requirements:	115
6. Health Status—Data Collection Tool	116
7. Certification of Employee Eligibility	117
8. Carrier Reporting to OHIC	118
9. OHIC Education Efforts	119
i. Website	119
ii. Speakers Bureau and Community Education Efforts	121
10. Notification to OHIC on Market Entrance	121
11. Definition of Small Employer and Affiliates	122
F. Impacting the Cost of Care	122
1. Medical Management	122
2. Utilization Management	124
3. Generic Substitution	124
4. Assistance with RlteShare	125
5. Continuation of Coverage	125
Conclusion: Achievement of the Purposes of the Act	127
Appendix A: Market Conduct Examination Recommendations for Blue Cross Blue Shield of Rhode Island	129
Appendix B: Market Conduct Examination Recommendations for United HealthCare of New England and United HealthCare Insurance Company	131
Appendix C: Glossary	135
Appendix D: Producer Survey	143
Questions for Producers	143
Appendix E: Cost Drivers	145
Hospital Utilization	145

**The Effectiveness of the Small Employer Health Insurance Availability Act in Promoting Rate Stability,
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December, 2006

Christopher F. Koller, Health Insurance Commissioner
State of Rhode Island and Providence Plantations
233 Richmond Street
Providence, Rhode Island 02903

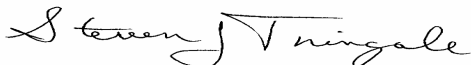
Dear Commissioner:

In accordance with your instructions and pursuant to the requirements of R.I. General Laws § 27-50-9, the attached report contains the results of an independent actuarial study and a report of the effectiveness of R.I. General Laws §§ 27-50-1, *et seq*, the Small Employer Health Insurance Availability Act ("the Act") in promoting rate stability, product availability, and coverage affordability.

The study incorporates findings from market conduct examinations completed this year of compliance with the Act by the two major carriers in the Rhode Island small employer market. A third market conduct examination is still in process. Should the results of this examination change the overall conclusions in the attached report, we will issue an addendum.

Respectfully submitted,

Hinckley, Allen & Tringale, LP



Steven J. Tringale, Managing Partner



Elinor Sochowitzky, Senior Principal

DeWeese Consulting, Inc.



Charles C. DeWeese, FSA, MAAA, FCA
President



Anthony J. van Werkhoven, PhD, FSA, MAAA
Consulting Actuary

Executive Summary

Introduction

The recent market conduct examinations of the small employer group health insurance business in Rhode Island reveal opportunities to improve the market for all stakeholders.

The following policy report was prepared in fulfillment of the requirements of *The Small Employer Health Insurance Availability Act* (R.I.G.L. §§ 27-50-1, *et seq.*, Chapter 27-50, or *the Act*). This report provides a comprehensive description of the regulatory environment, including major elements of the Act, small employer enrollment, group size and benefit plans. It also reviews the rate components at the two major carriers. Compliance issues identified as a result of the market conduct examinations follow the market overview. Next, a producer survey provides feedback from major marketers of small employer coverage. This policy report concludes with recommendations which have the potential to level the playing field, encourage enrollment and moderate costs within the small employer health insurance market. A list of the major recommendations of the study follows this Executive Summary.

Months of work from all parties went into completing the research, analysis and reporting of this information. The market conduct examinations of the small employer carriers in Rhode Island support the recommendations made in this report. This executive summary serves to provide a review of key facts and findings. We encourage everyone, but in particular leaders in the field of health care coverage, to give both the Executive Summary and the following report a careful reading in order to take full advantage of the findings.

Regulatory Objectives

In order to keep the examinations' findings in perspective, we list below the major purposes of the Act, as stated in R.I.G.L. §§ 27-50-2:

- To enhance the availability of health insurance coverage to small employers regardless of their health status or claims experience;
- To prevent abusive rating practices;
- To prevent segmentation of the health insurance market based upon health risk;
- To spread health insurance risk more broadly;
- To require disclosure of rating practices to purchasers;
- To establish rules regarding renewability of coverage;
- To limit the use of preexisting condition exclusions; and
- To improve the overall fairness and efficiency of the small group health insurance market.

Finding 1: Total Enrollment Has Decreased

The two major small employer insurance carriers are Blue Cross & Blue Shield of Rhode Island (BCBSRI) and United HealthCare of New England and United HealthCare Insurance Company (considered jointly as United). Total enrollment has decreased in the small employer market. From 2003 to 2005, BCBSRI lost 1,239 or 9% of its groups and nearly 20,000 members, representing 17% of its small employer members. United's membership has increased during the study period, but not enough to account for the decreases at BCBSRI.

Incorporating the membership numbers United reported to the Department of Business Regulation (DBR), total Rhode Island small employer enrollment decreased from 138,180 members in 2003 to 119,036 in 2005, a decrease of almost 14%. While we

believe that some of these individuals have moved to Direct Pay coverage or to coverage with other employers, many are probably part of the increase in the number of uninsured that Rhode Island has experienced over the past few years.

Finding 2: Average Group Size is Smaller at BCBSRI

In 2005, the average group size for United was 5.2 subscribers and for BCBSRI it was 3.8 subscribers. We believe the following factors have contributed to this difference: United started enrolling groups of one only in October, 2004, while BCBSRI has been enrolling groups of one far longer; United uses a more extensive medical history questionnaire at the time of enrollment for the smallest groups; BCBSRI makes more extensive use of intermediaries; and United uses preexisting condition limitations for a portion of its business.¹

Finding 3: More Attention Needed to Managing Groups of One Subscriber²

In 2005, approximately 26,000 persons were either covered by a Direct Pay policy from Blue Cross or enrolled in a small group of one subscriber at either BCBSRI or United. Managing groups of one subscriber is important, as the potential for adverse selection in this population segment is higher than it is for larger groups. This is because one individual can estimate with more accuracy than even a group of two whether or not there will be a need for health care services—and thus whether or not claims will be incurred—in the near future.

The three policy options for coverage of groups of one are to (a) eliminate sole proprietors from the definition of small employer; (b) merge the small employer and Direct Pay pools; or (c) maintain the status quo.

¹ United's use of pre-existing condition limitations is the subject of Recommendation 20 in the United market conduct examination report. The complete set of recommendations is included as Appendix B in this paper.

² It is important to note that the analysis of small groups of one is based on groups of one subscriber, whether or not there are other eligible employed individuals who chose not to enroll in the employer's coverage. This is because the data we obtained do not reliably detail the total number of eligible individuals, only the number of enrolled subscribers.

We believe that over the long term there is much to be gained from the merger of the small group and Direct Pay lines of business. However, at the present time **we recommend** continuing the status quo while conducting a study of:

- the impact of adverse selection,
- the impact of various underwriting scenarios to limit adverse selection,
- the ability of new small businesses to obtain coverage,
- analyses of the breakdown of the current direct pay population between sole proprietors and others,
- the differing health insurance needs and desires (if any) between sole proprietors and other current Direct Pay members,
- the potential impact of the merger of the two pools on carriers which currently provide Direct Pay coverage and carriers that do not,
- carrier reaction to the requirement to accept all individuals into the small employer pool, and
- the potential impact of such a merger in the absence of an individual health insurance mandate.

The results of this study will enable OHIC to design an informed process for merging the two markets if deemed appropriate.

Finding 4: Product Portfolio

Product Finding A: Product Portfolio is Cumbersome and Complex; Streamline and Improve Education Efforts

Each of the two major carriers offers over fifty benefit plans to small employers. This makes it extremely difficult for producers and purchasers to conduct meaningful product comparisons and to understand the value represented by each option. Despite the number of plans, 75% of subscribers at each carrier are in its five most popular medical plans.

With regard to product portfolios, **we recommend** that:

- Subject to approval from the Office of the Health Insurance Commissioner (OHIC), each carrier be permitted, within state and federal requirements for continuation of coverage, to discontinue unpopular products and streamline product portfolios; and that
- Carriers and OHIC educate employers, intermediaries and producers about the availability of plans with greater cost-sharing options.

We believe the second recommendation—a comprehensive education effort—is particularly critical. Such an effort may increase the number of employers which provide coverage and/or the number of employees who enroll. Product simplification should also decrease administrative costs by decreasing the time producers and sales staff need to explain plan options to employers.

Transitioning employees to products with appropriately designed higher levels of cost-sharing can change utilization patterns and thus result in premium savings above those expected from straight cost-shifting to the entire pool of insured individuals. For example, raising the copayment for emergency room visits is a simple way to discourage inappropriate use of the emergency room. The savings to the health insurance system are much greater than the simple differential in copayment levels because even unnecessary emergency room visits frequently result in multiple tests and/or procedures which increase overall costs.

Strategies for implementing portfolio changes and other reforms include web-based vehicles readily accessible to producers, carriers and employers. **We recommend** that OHIC build and maintain a website with unbiased product comparisons, standard health history forms and links to relevant information sources. OHIC can produce short podcasts featuring small employer group health insurance updates. For more comprehensive information-sharing, we suggest producing webcasts on key issues, including Q&A sessions that will keep the information relevant and foster dialogue.

Additionally, consumer-friendly collaterals that tie into web-based programming will increase reach and retention. These strategies have proved successful in other states.

Product Finding B: United's popular plans have more cost-sharing than those of BCBSRI

The breadth of product offerings—from comprehensive to less comprehensive—differs at each carrier. With a benefit value of “1” representing the most comprehensive product available, the average benefit relativity at BCBSRI is 0.94 while at United it is 0.85. This may be due in part to the fact that United's marketing materials emphasize affordability while BCBSRI emphasizes the comprehensiveness of its coverage.

Finding 5: Finances

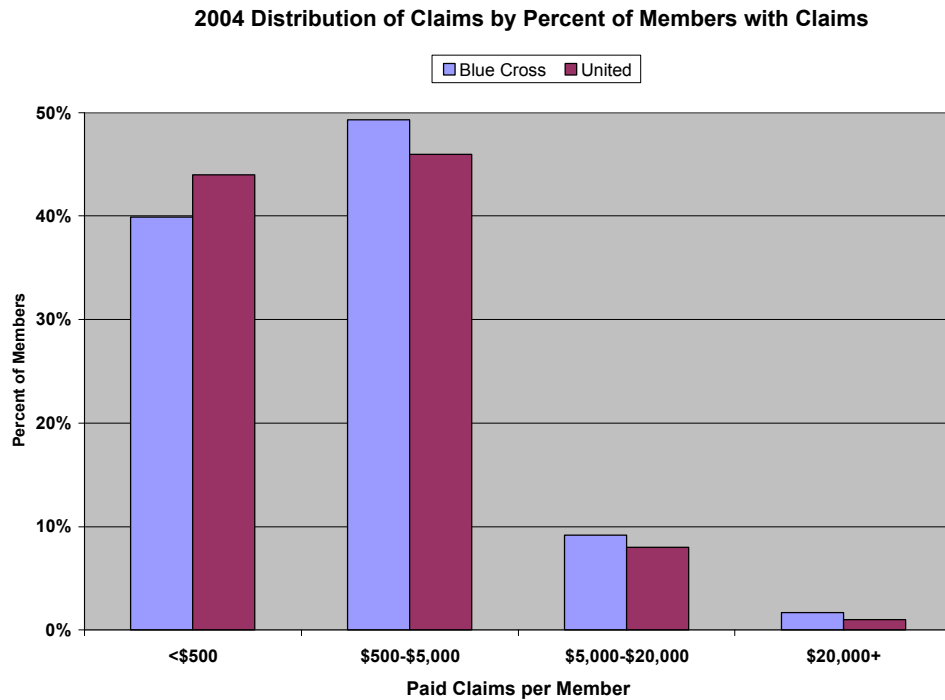
For rates effective November 2005, United's base rate for combined medical and prescription drug coverage for its HMO Choice products was approximately \$392. For BCBSRI, the base rate for its most popular products for the same effective date was approximately \$399. Accounting for the weighted average of benefit relativities of each carrier's most popular plans, the average base rates are approximately \$338 for United and \$390 for Blue Cross³. It thus appears that United has been successful with its marketing efforts that stress the affordability of its products, as the difference in the average base rates is due in part to the purchase of a greater percentage of products from United with higher cost sharing than those purchased from Blue Cross.

Finance Finding A: BCBSRI Has a Higher Percentage of Members with High Cost Claims

The chart below compares claim experience by percent of members with claims of various sizes across carriers.

³ These rates are then further adjusted for health status and age/gender factors, as well as a 4:1 compression (regulations require that the highest rate charged by a carrier for a specific contract type and benefit plan be no greater than four times the lowest rate charged by that carrier). The difference in average health status factors across the two carriers can widen the average difference between the base rates for the most popular plans.

The Effectiveness of the Small Employer Health Insurance Availability Act in Promoting Rate Stability, Product Availability, and Coverage Affordability



Note: United data based on a sample of claims, for members who had claims.

Because Blue Cross enrollment is significantly higher, it is important to view the distribution of claims by percent of claim dollars. Thirty percent (30%) of BCBSRI small employer claims are represented by members with claims of \$20,000 or more in a given year, while at United the comparable figure is 25%. Part of this difference may be due to the fact that United's emphasis on affordable health plans may attract younger and healthier individuals who do not anticipate incurring large claims. However, **we recommend** that OHIC monitor this difference.

Finance Finding B: United Has Higher Profit Ratios

The average loss ratio in 2005 at BCBSRI was approximately 84%, although it varies by benefit plan. For United, the average loss ratio was approximately 77%.

Our findings indicate that in 2004, administrative expenses at United were approximately 12% of premium. United's commissions and producer incentive

payments are approximately 6% of premium⁴, leaving approximately 5% for contribution to reserves and profit. At BCBSRI, approximately 11% of the rate goes toward administrative expenses, 3% for commissions and producer incentive payments, and 2% for contribution to reserves.

Finance Finding C: Carriers Differ Greatly in the Magnitude of Producer Bonus Payments

The distribution costs are the costs paid by a carrier to a broker, intermediary, general agent or other producer. Both BCBSRI and United build the cost of producer commissions and bonuses into the rates charged to all small employer groups.

The small employer community paid approximately \$13 million dollars⁵ in external distribution costs through its health insurance premium rates in 2005. The distribution of producer reimbursement between commission and bonuses is different for each carrier.

At United, bonuses represented 20.7% of commissions while at BCBSRI bonuses represent 3.4% of commissions paid.

Finance Finding D: Recommendations for the Small Group Health Insurance Distribution System

1. Increased Transparency

- We recommend that OHIC require carriers to work with only those producers who disclose to their clients the monthly and projected annual commission they will receive as a result of placing the client's business.
- We recommend that all carriers be required to file their small employer commission schedules, including any incentive compensation schedules, with OHIC.
- We recommend that each carrier be required to itemize the external distribution costs in its proposals and renewals to all employers so that they

⁴ United's commission database included some Massachusetts data, so that this number may be overstated.

⁵ See prior footnote

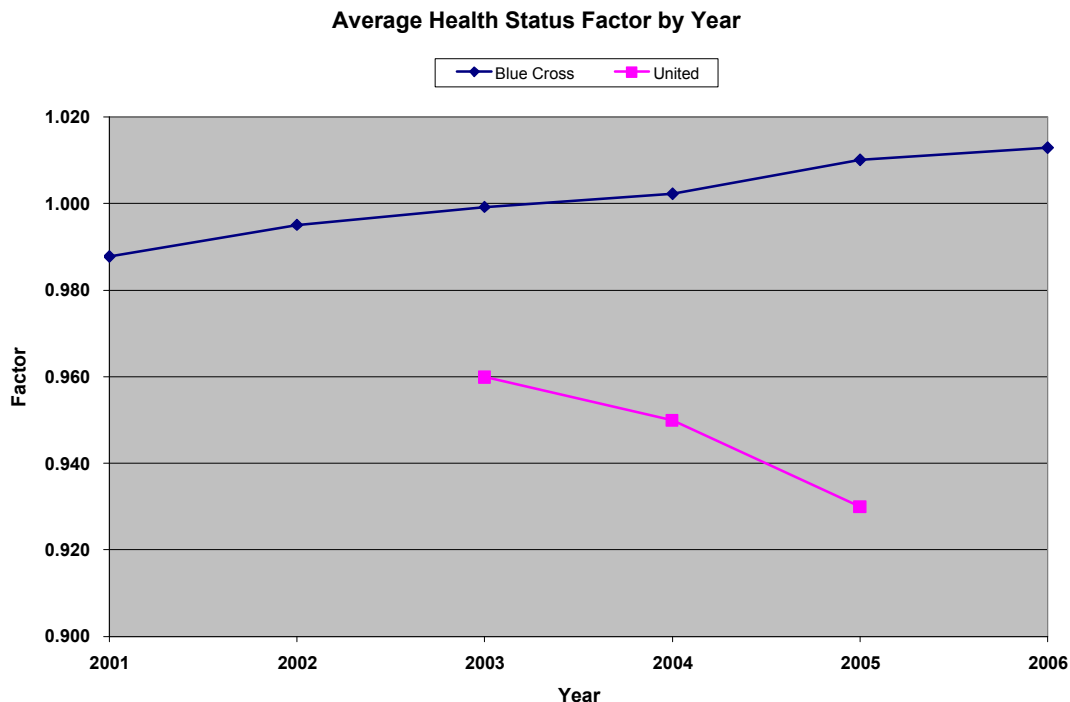
are made aware of what is included in the rates for the external distribution channel.

2. Prohibition of Volume or Persistency Bonuses.

As a further step toward eliminating any financial incentive on the part of a producer to recommend a specific carrier and/or benefit plan to an employer, **we recommend** that volume and/or persistency-based bonuses be prohibited in the small employer market.

Finding 6: Carriers' Evaluation of Members' Health Status Moving in Opposite Directions

The Act allows carriers to use health status factors to impact the adjusted community rate (ACR) by plus or minus 10%. The following chart depicts the average health status factor over time at the two major carriers. As the chart shows, the average factor is gradually increasing at Blue Cross and decreasing, less gradually, at United.



Also of note is that United's health status factors center in the low 0.90s while BCBSRI's average health status factors hover closer to 1.0.⁶

United rated 58% of its groups in the healthiest rated category in 2003; this increased to 75% of groups by 2005. BCBSRI was categorizing 31% of its groups in its healthiest category in 2003; by 2005, BCBSRI was categorizing only 14% of its groups in its healthiest category. The changing distribution of health status factors could be due to either a change in each carrier's evaluation of health risk or a true change in the health status of each carrier's members. In addition, the methodology used by United to develop health status factors is the subject of a compliance recommendation.

United's methodology for determining health status factors may have made United's rates relatively less attractive to employers with higher expected claims levels. The generally lower health status rankings at United could also be due to disincentives for the sickest groups to purchasing United's health plans that result from United's use of a more detailed medical history questionnaire for small groups and its marketing emphasis on lower cost benefit plans with more cost sharing. All of these factors combined may have positioned United as the more attractive carrier for lower utilizers of care.

We recommend the use of a standardized medical history questionnaire as one means of leveling the playing field.

Finding 7: Current Rating Requirements are Consistent with Legislative Goals

Both major carriers are interested in seeing changes to the allowable rating variables. The changes proposed by the carriers would serve to lessen cross-subsidies within the small employer pool and increase premium rates for those expected to use more services, while decreasing rates for those expected to use fewer services. List billing

⁶ The fact that United's health status factors average in the low 0.90s is the subject of a compliance recommendation. See Appendix B.

was also suggested. While each of these suggestions may be viewed by some as increased “accuracy” in rates, they are also contrary to one of the purposes of the Act—spreading health insurance risk more broadly. **We do not recommend** list billing or allowing rating variability by industry grouping or group size; **we do not recommend** increasing the current allowable health status adjustment spread or broadening the 4:1 compression requirement.

We recommend maintaining the ability to rate by health status and the 4:1 compression band as two means of continuing to meet the Act’s goal of spreading health insurance risk more broadly.

Finding 8: Consider Additional Protections to Ensure More Even Risk Distribution

- I. **Reinsurance or Risk-Adjustment**—Because of the existing disparity in the percentage of members with high claims experience between the two major carriers, **we recommend** that OHIC monitor this issue closely through a recommended change in the annual reporting requirement . This change will result in OHIC receiving more detailed information about the claims experience of the carriers. Should the disparity continue, we strongly recommend that OHIC either pursue the development of a high risk pool (funded either by premiums imposed on carriers or an external source) or use its existing authority to implement risk adjusters to distribute the cost of high cost enrollees across carriers.
- II. **Standardize Certain Carrier Administrative Practices**—**We recommend** standardizing the carriers’ medical history collection tools. We believe the standardization of the medical history collection tool will play a key role in evening out one element of unequal risk selection. **We also recommend** that the form for re-certification of enrollee eligibility be standardized, and that annual re-certification be conducted at the discretion of the carrier.
- III. **Managing Small Employer ASO Business**—The marketing of administrative services only (ASO) agreements, or partial ASO agreements, to small employers is

taking place in Rhode Island. Because ASO sellers segment the marketplace, **we recommend** discouraging such sales. **We recommend** that the appropriate statutes be amended to prohibit all insurers and Third Party Administrators (TPAs) from providing administrative services only or stop loss insurance to self funded plans of small employers.

- IV. Rate Review**—Regulations currently do not include a requirement for carriers to file small employer rates with OHIC. However, United did not provide sufficient data to enable a complete and comprehensive determination of compliance with the provisions of Chapter 27-50. This resulted in a market conduct examination that was not complete, which suggests that a rate review process for carrier small employer rates may be necessary in the future. At a minimum, **we recommend** that a supplementary market conduct examination of United be conducted in the coming year to determine its implementation of the various recommendations contained in the examination report and its compliance with all the provisions of Chapter 27-50.

Finding 9: Producers Supportive of Product Streamlining, Cost-sharing and Transparency to Clients

Our producer survey focused on the operations of the small employer health insurance market, as well as the strengths and weaknesses of the small employer reform law. We invited ten producers to participate in this survey.

Key findings are as follows:

- The type of business a small employer is in is the key determinant of product purchased
- Value for money was determined by plan design and price
 - *Offering plans with more cost-sharing was the most frequently mentioned way to reach those employers who are not entering the market due to price*

- Improved customer service was a non-price issue that could improve enrollment.
- Respondents saw no problem with streamlining product portfolios. Several producers mentioned that the multiplicity of products at each carrier resulted in confusion in the marketplace.
- Producers interviewed did not express concern with increasing the transparency of distribution costs to clients.
- With respect to the ideal role for the state, more than one producer advocated mandatory coverage (perhaps at a specified minimum benefit level) and/or employer assessments (or tax breaks for those employers which offer coverage). Efforts to increase competition and/or ensure all carriers are on an equal playing field were also suggested. Education of employers and consumers re: managing health care costs was another potential role for the state

Finding 10: Affordable Health Insurance Requires More Than Cost Shifts

As a part of our review of enrollment, rating practices and carrier compliance, we were asked specifically to consider how our findings might impact the issue of affordability. Market conduct and rating requirements primarily impact the way that the cost of health care is distributed among covered persons and among carriers; they do not typically impact the underlying cost of care. The new wellness plan called for by the Legislature is designed in part to increase the affordability of coverage. During the course of our discussions and analyses, however, we have identified a number of steps in addition to implementing the wellness plan that OHIC, employers, carriers and others can take to impact the cost of medical care itself. **Suggestions** for impacting the underlying cost of care include:

- Enhanced medical management and utilization management

- Encouragement of generic substitution for prescription drugs
- Changes in data collection from carriers to assist enrollment in RIteShare
- Expanded coverage continuation requirements

Conclusion

As part of its oversight of the small employer group health insurance market, OHIC initiated this effort and thereby created an opportunity to improve accessibility and affordability, which has the potential to reverse the negative enrollment trends in the Rhode Island Small Employer Group Health Insurance market. While our findings and policy recommendations point out that there is much work to be done to achieve all the goals set in motion through the promulgation of the *Small Employer Insurance Availability Act*, we believe OHIC will find the actionable recommendations have the potential to level the playing field, increase enrollment, stabilize risk pools and moderate costs over the long term, thereby enhancing the market for all stakeholders.

Key Recommendations⁷

A. Managing Groups by Size, Particularly Groups of One Subscriber

- 1) Require each carrier to maintain its small employer pool, including groups of one eligible employee, as one block of business for rating purposes
- 2) Study the potential for merging the small employer and Direct Pay rating pools

B. Product Portfolio

- 1) Encourage each carrier to streamline its product portfolios, subject to OHIC approval of the process
- 2) Enable carriers to provide information about only selected products to prospects and on renewal, subject to OHIC approved criteria.
- 3) Develop and maintain a website and Speakers Bureau to educate employer groups about small employer health insurance coverage; OHIC to develop materials as well.

C. Distribution System

- 1) Eliminate volume and/or persistency-based bonuses
- 2) Require carriers to work only with broker(age)s that disclose to clients the projected annual commission amount which they receive for placing the client's business

⁷ Not all recommendations on this list are discussed in the Executive Summary. Please refer to the body of the report for the rationale for each.

- 3) Require all carriers to file commission schedules with OHIC
- 4) Require carriers to itemize external distribution costs in proposals and renewals given to employers
- 5) For the longer term, discuss with the producer and carrier community the following:
 - i. Adding external distribution costs as a rating variable not subject to compression and
 - ii. Having producers bill clients directly

D. Rating Requirements

- 1) Maintain the current rating methodology, including the currently permitted rating variables and 4:1 compression, for groups of all sizes
- 2) Continue to prohibit list billing
- 3) Consider the establishment of a minimum loss ratio requirement

E. Additional Protections for More Even Risk Distribution

- 1) Study the appropriateness and effect of implementing risk adjusters should the need arise in the future
- 2) Prohibit Third Party Administrators (TPA)s from selling ASO⁸ business to small employer groups⁹

⁸ ASO is an abbreviation for “administrative services only”. This is a non-insured product, generally sold in conjunction with an insured product to limit the employers claim risk.

⁹ Should this not be possible, we would recommend protecting small employers by requiring extremely low levels of stop loss to be purchased together with ASO business.

The Effectiveness of the Small Employer Health Insurance Availability Act in Promoting Rate Stability, Product Availability, and Coverage Affordability

- 3) Periodically review the need for a filing requirement for small employer rates
- 4) Develop and require the use of standardized data collection tools for collection of medical information by the carrier to be used in developing health status factors
- 5) Eliminate the requirement for employee eligibility certification after initial enrollment; carriers shall be permitted to recertify groups at their own discretion
- 6) Revise the annual carrier reports to OHIC so that OHIC receives information which will be useful in monitoring changes in the marketplace
- 7) Require carriers new to the market to notify OHIC when the carrier's first quotation is issued to a Rhode Island small employer

F. Impacting the Cost of Care

- 1) Require carriers to report their medical management efforts to OHIC; subsequent to this, carriers and OHIC should jointly devise improvement goals for the small employer population
- 2) All parties work with DOH to explore appropriate improvements to utilization management regulations
- 3) Eliminate the ability for patients to over-ride a physician's determination that a pharmacist may substitute a generic medication in place of a brand name drug
- 4) Require carriers to provide RlteShare with timely benefit plan information
- 5) Require carriers to notify RlteShare when employees are terminated from small employer coverage

- 6) Revise the Rhode Island Extended Medical Benefits eligibility requirements to add all COBRA eligibility provisions (e.g., voluntary termination)

Introduction

The Small Employer Health Insurance Availability Act (R.I.G.L. §§ 27-50-1, et seq., Chapter 27-50, or the Act) requires a periodic independent actuarial study and report. “The report shall analyze the effectiveness of the chapter in promoting rate stability, product availability, and coverage affordability. The report may contain recommendations for actions to improve the overall effectiveness, efficiency, and fairness of the small group health insurance marketplace. “(The Act, Section 9.) The Office of the Health Insurance Commissioner¹⁰ (“OHIC”) contracted with Hinckley, Allen & Tringale LP (HAT) to conduct this study and prepare policy recommendations based on the results. HAT contracted with DeWeese Consulting, Inc. (DCI), an actuarial consulting firm, to perform market conduct examinations of the carriers and collect the required data, and to assist with development of the policy report. The prior small employer report was prepared in 2002, just two years after the effective date of the Act. This policy report provides information about small employer health insurance in Rhode Island from 2003 through 2005.

The recently completed market conduct examinations for the major carriers in the Rhode Island small employer market are available from OHIC. The two major carriers are Blue Cross & Blue Shield of Rhode Island (BCBSRI or Blue Cross) and United HealthCare of New England, Inc. and United HealthCare Insurance Company (considered jointly for the purposes of the market conduct examinations and identified in this report as United).

Blue Cross is a Rhode Island non-profit hospital and medical service corporation, an independent member of the Blue Cross Blue Shield Association organized to serve the

¹⁰ OHIC was created in accordance with the Rhode Island Health Care Reform Act of 2004 (R.I.G.L. §42-14.5). OHIC has authority with regard to compliance with Chapter 27-50. Prior to the creation of OHIC, the Rhode Island Department of Business Regulation (DBR) had authority with regard to compliance with Chapter 27-50. OHIC and DBR are used interchangeably in this report.

state of Rhode Island. United HealthCare of New England, Inc. and United HealthCare Insurance Company are two affiliates within UnitedHealth Group, an insurance holding company system. United HealthCare of New England is a Rhode Island domiciled and licensed Health Maintenance Organization, and United HealthCare Insurance Company is a Connecticut domiciled life insurance company licensed and authorized to issue life insurance, annuities and accident and health insurance for delivery in Rhode Island.

The recommendations in the market conduct examination reports are designed to ensure that each carrier complies with the requirements of the Act. (Please refer to Appendices A and B for the recommendations for each major carrier.)

The purpose of this report is to describe the overall state of the small employer health insurance market in Rhode Island and to make recommendations for policy changes. This policy report draws heavily on the two market conduct examination reports for the major carriers; the policy recommendations are based primarily on the findings of the market conduct examinations and the data contained in the two resulting reports.

During the course of the examinations, it became apparent that a third carrier—MEGA Life and Health Insurance Company (MEGA)—also operates in the small employer market in Rhode Island. Based on preliminary data, MEGA insures approximately 1.6% of the small employer market. The MEGA market conduct examination is still in progress. Preliminary information suggests that eliminating the current volume of MEGA small employer business from the analysis will not dramatically change the findings presented in this report. If the MEGA market conduct examination results in a change to our findings, or if we determine that any new policy recommendations are needed as a result, we will issue an addendum to this report.

After explanatory information about the purposes and major elements of the Act, this policy report consists of four major sections:

- an overview of the market, including a statistical description of the small employer health insurance market;

The Effectiveness of the Small Employer Health Insurance Availability Act in Promoting Rate Stability, Product Availability, and Coverage Affordability

- a summary of compliance issues found during the carrier-specific market conduct examinations;
- a summary of a survey of producers; and
- recommendations for policy decisions to assist in achieving the purposes of the Act.

Please refer to Appendix C, a Glossary, for a definition of insurance terms used in this report.

The Purposes of the Act

The Small Employer Health Insurance Availability Act became effective July 13, 2000. As stated in the Act, it was not intended to provide a comprehensive solution to the problem of affordability of health care or health insurance.

The purposes of the Act, as originally stated in R.I.G.L. § 27-50-2, are to:

- Enhance the availability of health insurance coverage to small employers regardless of their health status or claims experience;
- Prevent abusive rating practices;
- Prevent segmentation of the health insurance market based upon health risk;
- Spread health insurance risk more broadly;
- Require disclosure of rating practices to purchasers;
- Establish rules regarding renewability of coverage;
- Limit the use of preexisting condition exclusions;
- Provide for development of “economy” , “standard” and “basic” health benefit plans to be offered to all small employers; and
- Improve the overall fairness and efficiency of the small group health insurance market.

Elements of the Act

In order to achieve the specified purposes, the Act and the associated Insurance Regulation 82 (the “Regulation”) specify:

- Eligibility requirements for both new business and renewals;
- Actions carriers need to take to ensure that only eligible small employers and their eligible employees are allowed to enroll in the health plan;
- Limitations on the factors carriers can consider when developing rates;
- Limitations on the way health insurance rates can be calculated;
- Marketing requirements; and
- Products required to be offered for sale.

A detailed description of the major requirements of the Act and the Regulation and the changes in the Act over time is contained in each carrier’s market conduct examination report. A more general description of the current eligibility and rating requirements follows¹¹:

A. Eligibility

- *Small employer means any employer with at least one and no more than 50 eligible employees. A self-employed individual is a small employer.*
- *An eligible employee is a permanent full-time employee working 30 hours or more in a normal work week. The employer may elect to reduce the 30 hour eligibility requirement to any level between 17.5 and 30 hours, as long as all*

¹¹ The italicized portion of the following narrative is designed for easy adaptation as an educational brochure for Rhode Island small employers.

employees are treated uniformly. Temporary employees are not eligible for coverage, even if they work full-time.

- *The employer must be actively engaged in business, with a majority of employees in Rhode Island or, if no state has a majority of employees, the employer's primary place of business must be in Rhode Island.*
- *Every small employer interested in insurance must be offered all small employer health plans that are available from the quoting carrier in the Rhode Island market as long as the small employer meets the carrier's minimum participation requirement, which can be no higher than 75%. The participation requirement is based on the percent of eligible individuals who actually enroll in coverage, excluding any employees who have other creditable coverage.*

B. Product Availability

- *A small employer may purchase any product offered by the carrier in the small employer market.*
- *Carriers are required by statute to offer certain health plans.¹²*
- *Carriers must market all products equally.*

C. Rating

- *Carriers are required to develop rates based on the combined experience of all the small employers that each carrier insures, adjusted only for selected characteristics which are described below. The requirement for each carrier to use the combined experience of all the groups it insures as adjusted only by the allowed characteristics is called "adjusted community rating."*
- *Carriers are required to maintain a rate manual, from which all rates can be calculated.*

¹² Recent changes to the Act removed the requirement to offer the Standard and Economy plans and added a requirement to offer a wellness plan. OHIC issued the product requirements for the wellness plan to the carriers in mid-December, 2006.

- *The only factors which can cause a rate for a particular benefit plan to vary from one small employer to another are:*
 - *The effective date of the contract;*
 - *The age of the enrollees;*
 - *The sex of the enrollees;*
 - *The health status of the enrollees.*
- *The health status of enrollees can impact the group's rate by no more than plus or minus 10%. Thus, the health status of all enrollees in a group can lead at most to a 10% increase or a 10% decrease to what the rate would otherwise be.*
- *The health status factor is applied to the group as a whole.*
- *Carriers must offer the following four contract-types to small employers:*
 - *employee only,*
 - *employee and child(ren),*
 - *employee and spouse, and*
 - *employee, spouse, and child(ren).*

This is referred to as “four-tier composite” rating.

- *For a given effective date, benefit plan, and contract type, even after age, sex, and health status are taken into account, the highest rate charged any small employer group can be only four times as great as the lowest rate. This limit is referred to as “4:1 compression” in this report.*
- *Rates for a specific employer group will generally not change more often than once every 12 months.*

D. Renewal Requirements

- *Carriers are required to re-confirm and document all eligibility information every year.*
- *Renewal rates are calculated in a manner similar to an employer's original rates, using only the same allowable rating factors—age, gender, health status, and family composition.*
- *An employer cannot be denied renewal coverage based on prior claims experience.*

Key changes from the original Act are as follows¹³:

- Carriers have increased leeway to modify existing health benefit plans and/or eliminate such plans from their product portfolio.
- Carriers may continue to adjust rates based on health status (i.e., the phase-out of health status contained in the original version of the Act was eliminated).
- The expansion of the definition of small employer to include groups of one eligible employee was delayed from October 1, 2002 to October 1, 2004.
- The scheduled move to limit rate variation (for comparable effective dates, benefit plans and contract types) across employers to 2:1 rather than 4:1 compression was eliminated.
- Permissible minimum participation requirements were changed. While originally permitted, carriers cannot require a minimum participation level greater than 75% for all groups until October, 2006. After this date, the permissible minimum participation requirement for groups of ten or fewer changes to 100%.

¹³ For a more detailed description of changes in the Act from its original passage to the present, please refer to either the BCBSRI or United Market Conduct Examination Report.

**The Effectiveness of the Small Employer Health Insurance Availability Act in Promoting Rate Stability,
Product Availability, and Coverage Affordability**

Chapter 27-50 was recently amended by the General Assembly. Among other changes, the requirement to offer the Standard and Economy plans has been removed, and the provision allowing carriers to impose a 100% participation requirement for the smallest groups effective October 1, 2006 was deleted.

Findings—an Overview of the Market

A. Small Employer Enrollment

Blue Cross Blue Shield of Rhode Island is by far the largest carrier in the small employer market, although both its membership and market share have decreased since the last market conduct report in 2002. The other major carrier is United HealthCare of New England and United HealthCare Insurance Company, considered jointly as United. United's membership and market share have increased since the last report. During the course of the market conduct examinations we learned that MEGA has a small (approximately 1000 subscribers, all self-employed individuals) membership in Rhode Island. Due to the timing of the receipt of this information, and the ongoing market conduct examination of MEGA, this report focuses on the two major carriers—BCBSRI and United. We also have learned that programs which are not fully insured are being offered to, and accepted by, small employers in Rhode Island. Such programs are not subject to the requirements of the Act.

As of January 1, 2003, BCBSRI insured 13,777 small employer groups. These groups represented 58,419 subscribers and 115,380 total members. By January 1, 2005, BCBSRI insured 12,538 groups with 48,534 subscribers and 95,736 members. Thus, over the three year period BCBSRI lost 1,239 or 9% of its groups and nearly 20,000 members, representing 17% of its members, in its small employer block of business.

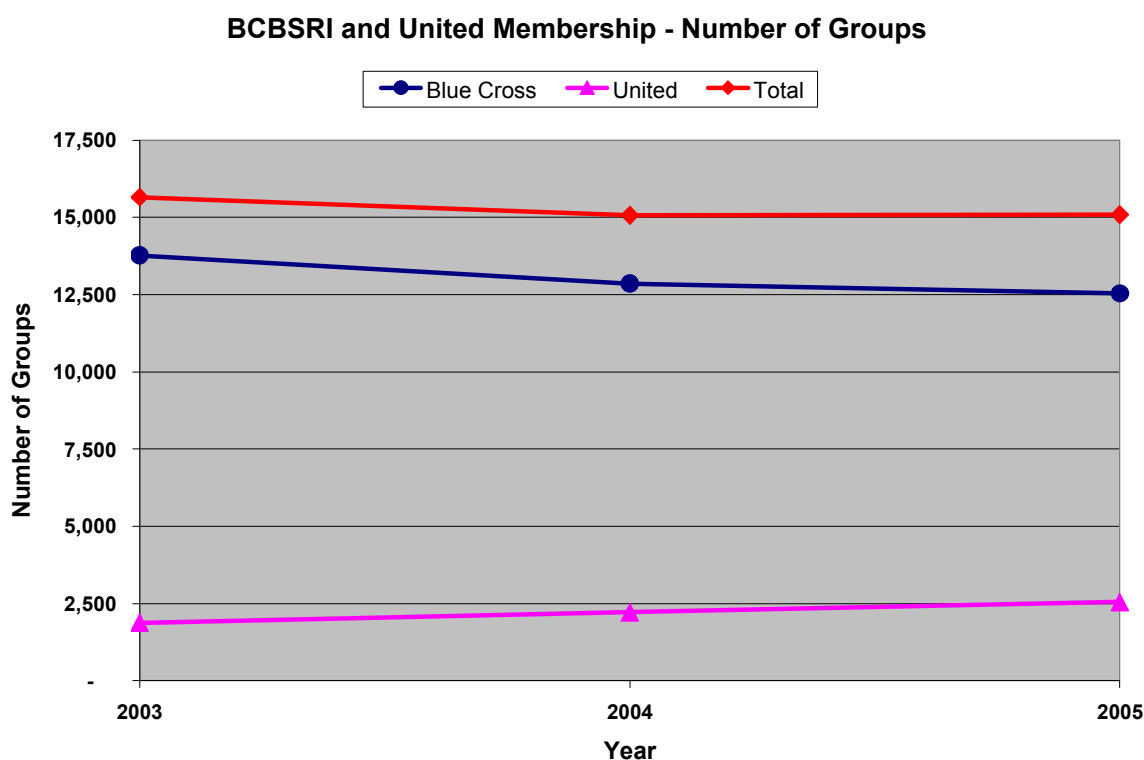
It is difficult to specify exact membership numbers for United, as we have obtained three different member counts. According to underwriting data provided by United during the market conduct examination, from 2003 to 2005 United gained 669 groups and 3,306 members. During 2003, United had 1,880 groups, 11,602 subscribers and 21,110 members. During 2005, United had 2,549 total groups, representing 13,222 subscribers and 24,416 members. This represents a 36% increase in the number of groups and a 16 % increase in members.

The Effectiveness of the Small Employer Health Insurance Availability Act in Promoting Rate Stability, Product Availability, and Coverage Affordability

In United's response to the draft market conduct examination, it stated that it believes its count of insured small employer members was approximately 20,800 at year-end 2003, 20,400 at year end 2004, and 21,300 at year-end 2005. According to data reported to the Rhode Island Department of Business Regulation in connection with its statutory filings, United's membership was approximately 22,800 at year-end 2003 and 23,300 at year end 2005.

While we have been unable to resolve the discrepancy in United's membership numbers, it seems clear that United's membership has increased. However, the increase in membership at United does not offset the decrease in BCBSRI membership.

The following charts depict the change in membership over time.



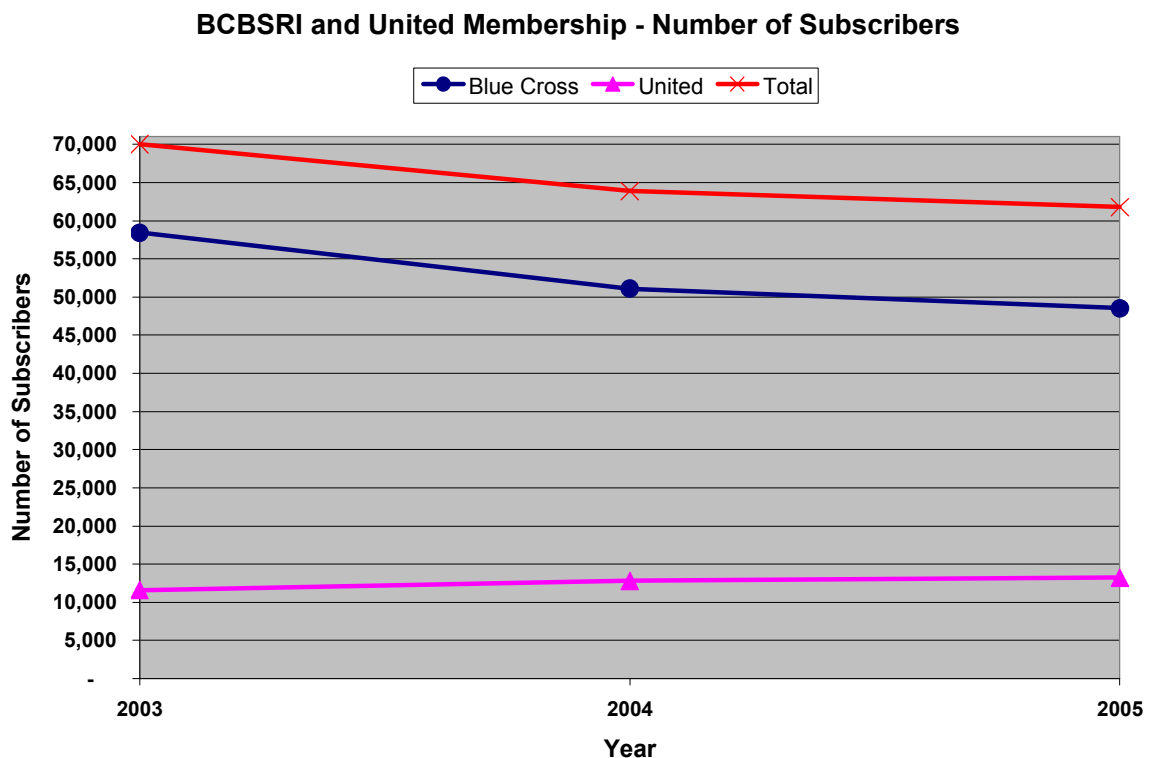
Note: Data for United is as of each group's effective date during the year, and is from Exhibit 1, which uses underwriting data, of the market conduct examination. Data for BCBSRI is as of the first of the year.

The total number of small employers enrolled in coverage across the two carriers changed from 15,657 to 15,087, for a decrease of 570 groups or 3.6%. Although United

The Effectiveness of the Small Employer Health Insurance Availability Act in Promoting Rate Stability, Product Availability, and Coverage Affordability

has increased the number of groups it insures, BCBSRI is still the dominant carrier by far.

Among the top two carriers, as the following chart depicts, the number of subscribers has decreased by 8,265, or 11.8%, from 2003 to 2005.



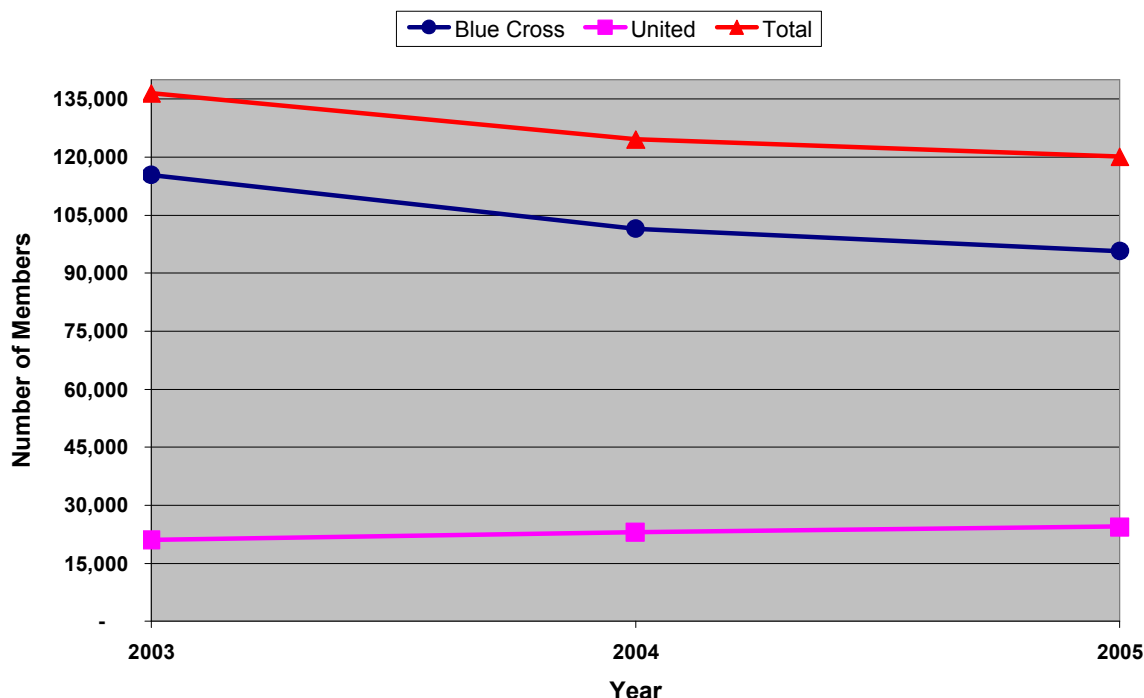
Note: Data for United is as of each group's effective date during the year, and is from Exhibit 1 of the market conduct examination. Data for BCBSRI is as of the first of the year.

Using the underwriting data from United, total Rhode Island small employer health insurance enrollment has decreased by 16,338 persons (from 136,490 to 120,152, or almost 12%) during this same time period.

Using the membership numbers United reported to the Department of Business Regulation rather than the underwriting data provided in response to examination data requests, total Rhode Island small employer enrollment decreased from 138,180 to 119,036, or almost 14%, from 2003 to 2005.

The Effectiveness of the Small Employer Health Insurance Availability Act in Promoting Rate Stability, Product Availability, and Coverage Affordability

BCBSRI and United Membership - Number of Members



Note: Data for United is as of each group's effective date during the year, and is from Exhibit 1 of the market conduct examination. Data for BCBSRI is as of the first of the year.

There are a number of possible reasons for the decrease in enrollment in the small employer market in Rhode Island. While the carriers have not collected reliable data on the reasons for cancellations of existing groups, we do know that many groups were cancelled by each carrier due to the inability of the group to meet small employer eligibility requirements, including minimum participation levels.¹⁴ Other groups were cancelled by carriers due to non-payment of premium or the fact that no members were left in the group. We must presume that some who didn't pay at one carrier either went to the other carrier or dropped coverage totally because the cost became prohibitive. We were able to track some groups that have moved from one carrier to the other. The

¹⁴ This may be the result of each carrier's implementation of procedural changes as a result of recommendations contained in the 2002 market conduct examinations. These recommendations encouraged strict enforcement of small employer eligibility requirements, as called for in the Act.

groups we were able to identify as moving from one carrier to another are generally larger than the average group size in the small employer market.

Changing employment patterns and the volatility of the small employer business climate in general account for some decrease as well. We have not, however, attempted to determine empirically why more small employers are not entering the market for health insurance. Producers mention price, but also state that many small employers simply are not interested in purchasing coverage, regardless of price. Please refer to the Producer Survey Results for a fuller discussion of information gleaned from the producer survey.

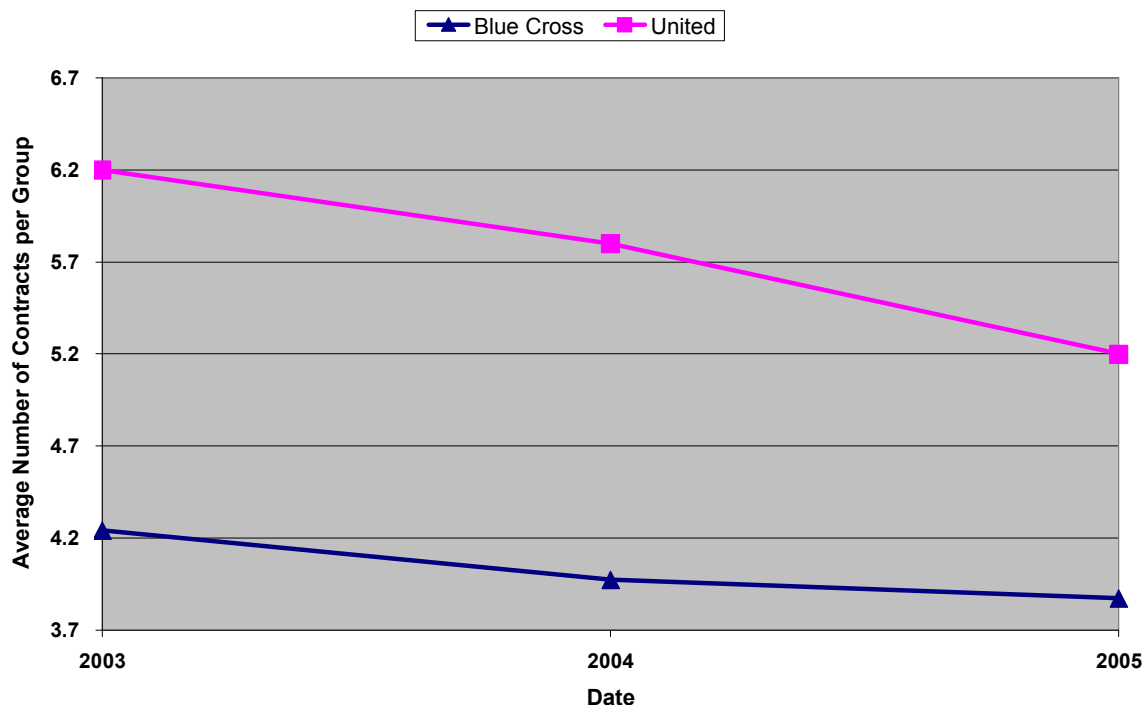
B. Group Size

Average group size has declined over time at both carriers.¹⁵ In this context, group size refers to the number of subscribers in a group. It is important to note that not all groups of one subscriber represent employers with only one eligible employee. A group with one enrolled employee could represent an employer with any number of employees, where all but one has waived coverage. A “waiver” of coverage occurs when an employee does not enroll in an employer’s health insurance coverage because he/she has access to creditable coverage elsewhere—most commonly through a spouse’s employer. A group of three enrolled employees, therefore, could represent an employer with six eligible employees, three of whom waived coverage.

¹⁵ While BCBSRI has made small employer health plans available to groups of one eligible employee since at least the time of the prior market conduct examination in 2002, United did not do so until required by the Act, in October, 2004. The addition of groups of one at United is one reason for the decline in average group size at United.

The Effectiveness of the Small Employer Health Insurance Availability Act in Promoting Rate Stability, Product Availability, and Coverage Affordability

BCBSRI and United Average Group Size Over Time



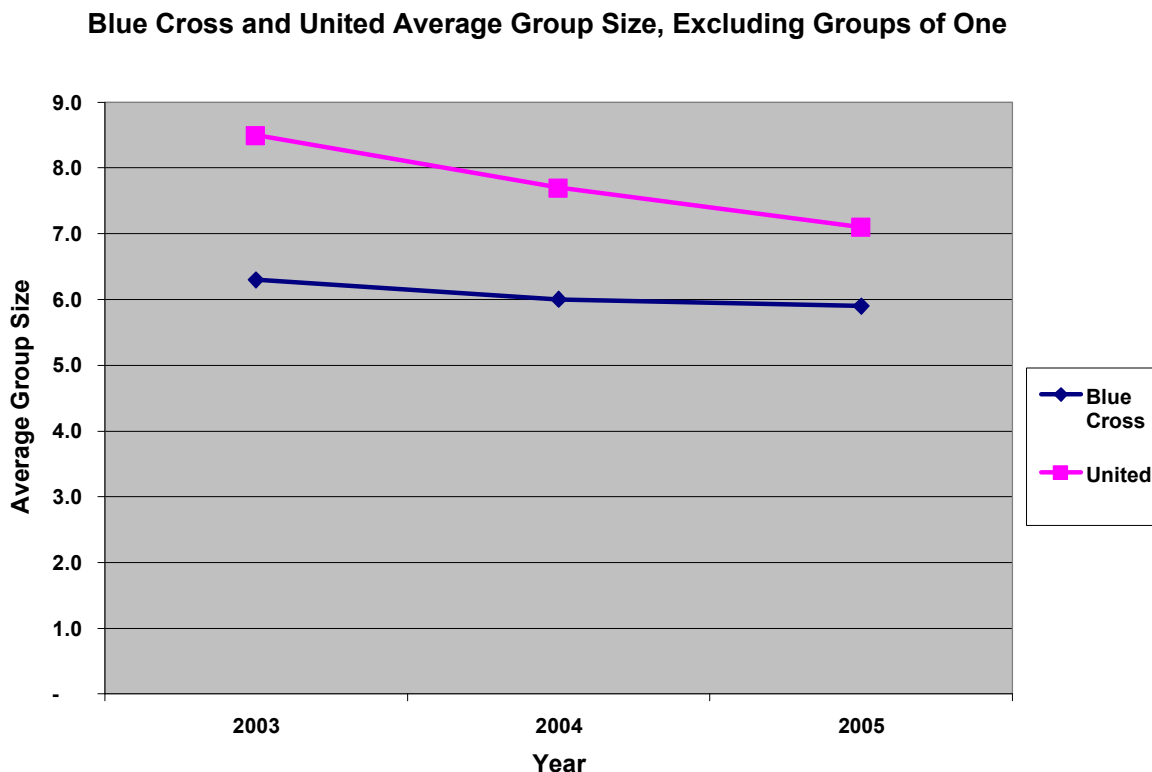
Note: Data for United is as of each group's effective date during the year, and is from Exhibit 1 of the market conduct examination. Data for BCBSRI is as of the first of the year.

At United, the decline in average group size is somewhat steeper than it is at BCBSRI at least in part because United only started enrolling groups of one when required, in October, 2004. As stated previously, BCBSRI has been enrolling groups of one since at least the time period covered by the prior market conduct examination beginning in 2000.

In 2005, the average group size for United was 5.2 subscribers and for BCBSRI it was 3.8 subscribers.

Eliminating employer groups with one subscriber from the group size calculation, the decrease in size of United groups is still somewhat steeper than the decrease in size of the Blue Cross groups. United groups, excluding groups with one member, decreased from 8.5 subscribers in 2003 to 7.1 subscribers in 2005, while BCBSRI group size on the same basis decreased from 6.3 subscribers in 2003 to 5.9 subscribers in 2005.

The Effectiveness of the Small Employer Health Insurance Availability Act in Promoting Rate Stability, Product Availability, and Coverage Affordability



Note: Data for United is as of each group's effective date during the year, and is from Exhibit 1 of the market conduct examination. Data for BCBSRI is as of the first of the year.

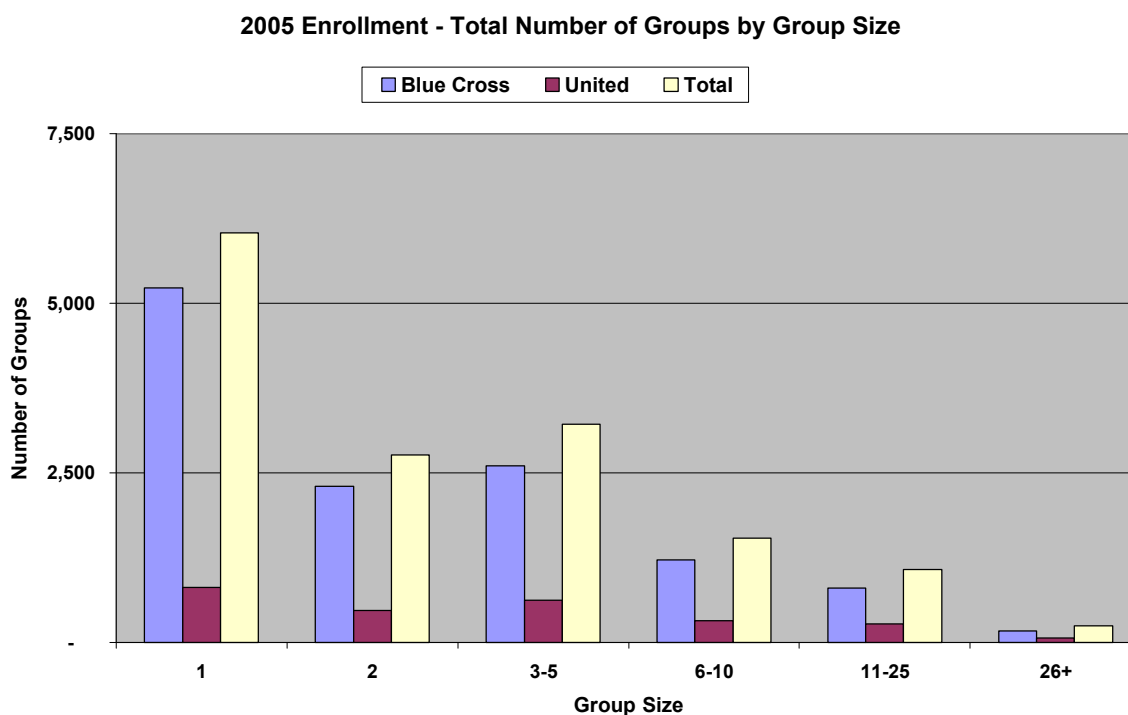
Typically, the larger the group the more attractive it is to a carrier. This is true for two major reasons. First, the cost of the administrative work effort required to attract, enroll, and maintain a group is spread across more enrollees. In addition, smaller groups are generally presumed to be poorer risks because they are most motivated to purchase coverage only when someone needs it. This latter reason is especially true of groups of one.

One way to limit this tendency is to permit carriers to impose pre-existing condition limitations. Such limits deny coverage of claims for a health problem which the member experienced within a certain length of time prior to purchasing coverage. The Act permits a six month pre-existing condition limit for people who enroll when first eligible and a twelve month pre-existing condition limitation for late entrants. Blue Cross does not impose any pre-existing condition limitations. Currently, United imposes limits six months longer than the Act's allowable time period for a small portion of its business,

The Effectiveness of the Small Employer Health Insurance Availability Act in Promoting Rate Stability, Product Availability, and Coverage Affordability

which is written under the insurance company license rather than the Rhode Island HMO. (This is in the process of being changed in accordance with the recommendation in the market conduct examination to conform to the Act.) The differences between carriers in the application of pre-existing condition limitations may also impact the choice of carrier by group size.

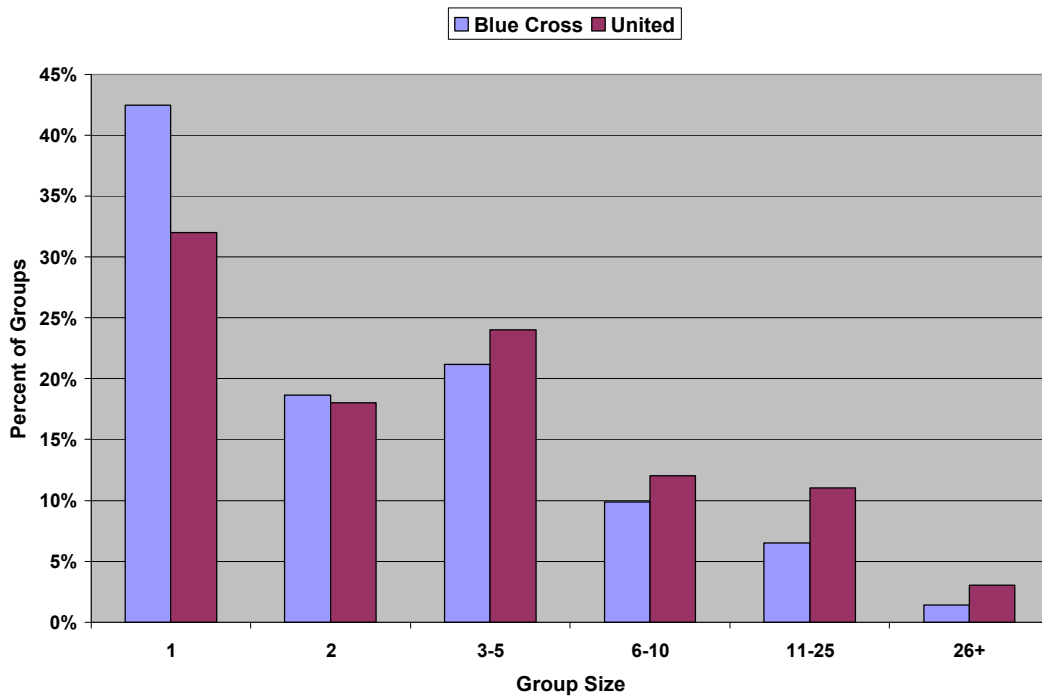
The chart below depicts the number of groups for each major carrier by group size, defined as number of subscribers, in 2005. Because its overall enrollment is higher than United's, BCBSRI is higher in all categories. The majority of groups for both carriers have five or fewer subscribers.



Looking at the percent of groups by group size shows more clearly than just looking at absolute numbers how each carrier's business breaks down by size. As the following chart depicts, United has a higher percent of groups in all categories except groups of one and two. BCBSRI has a much higher percent of groups of one than does United, and a slightly higher percent of groups of two.

**The Effectiveness of the Small Employer Health Insurance Availability Act in Promoting Rate Stability,
Product Availability, and Coverage Affordability**

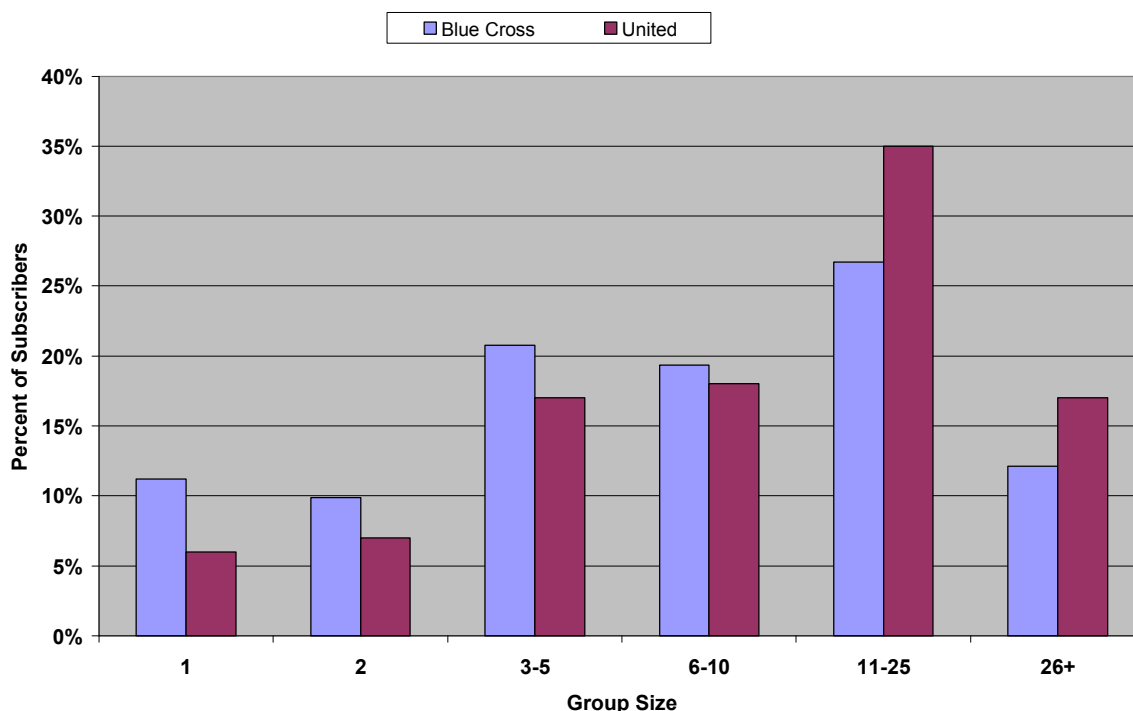
2005 Enrollment - Percent of Groups by Group Size



When we look at the percent of subscribers by group size, as would be expected, most subscribers are concentrated in the larger group sizes. However, it is interesting to note that United has a higher percentage of subscribers in groups of 11 subscribers or more than does Blue Cross. In 2005, for United, 14% of groups and 52% of subscribers were in groups of 11 or more, while for BCBSRI only 7% of groups and 39% of subscribers were in groups of 11 or more.

The Effectiveness of the Small Employer Health Insurance Availability Act in Promoting Rate Stability, Product Availability, and Coverage Affordability

2005 Enrollment - Percent of Subscribers by Group Size



We believe that differences in procedures employed by the companies may account for differences in the distribution by group size. One reason for this difference is that, as stated previously, United only began enrolling groups of one recently, so the overall distribution across carriers with respect to group size will take time to adjust. Even though pertaining only to United's insurance company rather than its HMO, differences between carriers in the administration of a pre-existing condition limitation might also have swayed smaller groups to Blue Cross, where no pre-existing condition limits are imposed. In addition, we suspect that the more extensive medical history form used by United for groups of fewer than ten employees may discourage some smaller groups from applying to United. (This issue is discussed more fully in the Health Status Factor section of the policy recommendations.) The emphasis on product affordability that United uses in its marketing efforts and pricing may also contribute somewhat to the differences in group size. To the extent that larger groups (where the benefits to the owner are less of a prime concern in health insurance purchasing) are more attractive to plans with cost sharing, these groups may be more interested in United's benefit plans.

C. Benefit Plan or Product Mix

The two major carriers each offer multiple benefit plans to small employers. BCBSRI has members active in 21 different medical benefit plans with three primary prescription drug options, while United has members active in 56 different plans. Part of this difference is due to the different definitions used by each carrier to define a benefit plan or product. If each company used a definition similar to that used by United, each carrier would have over fifty different benefit options.

Despite the number of products, 75% of subscribers at each carrier are in its five most popular medical plans. The most popular BCBSRI product is Health Mate Coast-to-Coast (HMC2C), with approximately 76% of Blue Cross small group subscribers. It is a Preferred Provider Organization (PPO) plan that relies on copayments to help manage utilization. There are ten different HMC2C options, with primary care physician (PCP) visit copayments ranging from \$10 to \$20, specialty physician visit copayments ranging from \$10 to \$25, emergency room visit copayments ranging from \$25 to \$100, and in-network calendar year deductibles ranging from \$0 to \$1,000. The overwhelming majority of HMC2C subscribers are enrolled in the richest HMC2C option. That option is paired with a prescription drug plan that has a \$7/\$25/\$40 copayment structure—\$7 copayment for generic drugs, \$25 copayment for preferred brand name drugs, and \$40 for non-preferred brand name drugs.

Blue Cross also offers a variety of plans designated as “Blue CHiP” or “CHiP” to small employer groups. These plans require the selection of a primary care physician and a PCP referral to receive additional services. BCBSRI considers these to be Point of Service (POS) plans. The plans have similar copayment options to the HMC2C plans. Most of the CHiP plans do not have an in-network calendar year deductible. Approximately 22% of small employer subscribers are enrolled in CHiP plans.

Blue Cross also offers “Classic” indemnity programs (with approximately 2% of total small employer subscribers enrolled), and the statutorily required Essential Care 4 and

5, described in Chapter 27-50 as “Standard” and “Economy.” As of October, 2005, 114 subscribers were enrolled in the two statutory plans.

Blue Cross’s most popular plans still involve very little cost sharing. There has been a slight trend toward modest increases in copayments.

United’s most popular plans are its HMP or Choice Plus products which provide open access Point of Service (POS) benefits on its Health Maintenance Organization (HMO) platform. Eighty-five percent (85%) of United’s small employer subscribers are enrolled in a plan issued by United HealthCare of New England, the Rhode Island-based health maintenance organization. The HMP products also have a range of cost sharing options. The trend in the last few years has been for subscribers to choose lower cost versions that have greater cost sharing. United’s most popular medical plan has a \$300 in-network deductible and a \$15 in-network physician office visit copayment. However, United’s new business groups are selecting lower cost plans with even higher deductibles. Among new groups, plans with higher deductibles (\$500 and \$1,000 respectively) and a \$20 office visit copayment are more popular than the \$300 deductible plan mentioned above. The lower cost plans also have lesser benefits for out-of-network care. One of the lower cost plans has specific deductibles that apply to inpatient care and outpatient surgery. All of these plans are less costly than the \$300 deductible plan.

The statutory plans are issued by both United HealthCare of New England and United HealthCare Insurance Company.

The United affiliate, United HealthCare Insurance Company, also sells small employer health insurance in Rhode Island. A total of 14% of United’s Rhode Island small employer subscribers are enrolled in UHIC Point of Service Choice Plus plans, with less than 1% of enrollment spread among all other types of insurance products.

United allows policyholders to select a pharmacy plan separately from the medical plan. There are three primary pharmacy plans available. The most popular of these provides a three tier pharmacy copayment structure of \$10 for generic drugs, \$30 for preferred

**The Effectiveness of the Small Employer Health Insurance Availability Act in Promoting Rate Stability,
Product Availability, and Coverage Affordability**

brand drugs and \$50 for non-preferred brand drugs. Fifty-eight percent (58%) of all groups, but 73% of new groups, choose this plan, which is the least expensive of the three major options.

A comparison of the most popular plan at each major carrier follows:

Carrier	BCBSRI	United
In-network Deductible	0	\$300 I/\$600 F**
Out-of-Network Deductible	\$200 I/\$600 F*	\$350 I/\$700 F
Out of Pocket Maximum Out-of-Network	\$3,000 I/\$9000 F	\$4,000 I/ \$8,000 F
In-network Coinsurance	n/a	20% for certain services***
Out-of-network Coinsurance	20%	30%
Office Visit Copayment	\$10	\$15
Urgent Care Copayment	\$10	\$25
Emergency Room Copayment	\$25	\$50
Inpatient Copayment	0	Deductible
Outpatient Surgery Deductible	0	Deductible
Pharmacy Copayment Levels	\$7/\$25/\$40	\$10/\$30/\$50

*I stands for individual; F stands for family.

** In-network deductible does not apply to office visits, outpatient, ER, Pharmacy, X-rays, therapeutic or laboratory services

***In-network coverage is 80% for certain services, including home health care, outpatient therapy, durable medical equipment, prosthetic devices, accidental dental services, infertility services, spinal treatments and ambulance services. United also has an in-network out of pocket maximum.

As can be seen from the above chart, the most popular plan for each carrier has fairly low cost-sharing levels; this is particularly true at Blue Cross. Office visit copayments are no greater than \$15 and emergency room copayment levels are no greater than \$50. However, new groups tend to choose options with greater cost-sharing levels at both carriers.

Of particular interest is the level of emergency room copayments—typically \$25 or \$50 at BCBSRI and \$50 or \$100 at United. The forty-four percent (44%) of BCBSRI subscribers who are in the most popular BCBSRI plan have an emergency room copayment of \$25. The Blue Cross small employers that have chosen a less expensive plan at renewal have changed primarily to a plan with a \$50 emergency room copayment. Among those enrolled in United’s five most popular medical plans (almost 75% of total members), approximately half are enrolled in a plan with a \$50 emergency room copayment and half in plans with a \$100 copayment. Low emergency room copayment levels are discussed more fully in the Product Portfolio section of this report.

It is also worth noting that developing the above comparison chart was not a simple task, even for trained observers with full access to company documents. This difficulty exists because each carrier’s marketing materials and benefit descriptions are organized differently. The plethora of product variations and the different approaches to presenting benefit designs make product comparisons across carriers rather complex.

A good means of comparing products across carriers is to look at benefit relativities, although this method is not generally available to consumers. Benefit relativities provide the carrier’s estimate of the overall value of the benefits in each plan. Carriers have generally assigned a value of “1.00” to the product with the most generous benefits; each other product is described as a fraction of one. Different employer groups may choose different cost-sharing options (e.g., office visit or emergency room copayment levels, an up-front deductible, coinsurance rather than flat copayments, etc). The benefit relativity factor takes all this into account and combines it into one number.

The Act requires that carriers price different benefit designs based solely on benefit differences.¹⁶ The relativities are meant to capture these benefit differences.

¹⁶ In large employer business, in addition to benefit differences, carriers will typically consider the health status of individuals likely to enroll or actually enrolled in a product in pricing the product or benefit plan for a specific large employer. Thus, to the extent that generally healthier employees enroll in products with large upfront deductibles while relatively less-healthy persons

**The Effectiveness of the Small Employer Health Insurance Availability Act in Promoting Rate Stability,
Product Availability, and Coverage Affordability**

The following table depicts the benefit relativities of the most popular products for each of the two carriers, accounting for approximately 75% of subscribers for each carrier. Because United permits its prescription drug plans to be purchased in combination with multiple medical plans, more combinations are required to reach approximately 75% of total subscribers. We have therefore grouped multiple plans together. These combinations, however, represent only five different medical plans for United.

Distribution of Membership in Each Carrier's Most Popular Plans

BCBSRI		United	
Plan Benefit Relativity	Percent of Subscribers	Plan Benefit Relativity*	Percent of Subscribers
1.00	44%	1.00	8%
0.95	6%	≥0.85 & <0.90	31%
0.94	6%	≥0.80 & <0.85	26%
0.92	10%	>0.75 & <0.80	7%
0.89	10%	0.75 or less	3%

*Weighted average benefit relativity for medical and prescription drug plans combined.

The range of benefit relativities for the most popular BCBSRI plans is from 0.89 to 1.00; at United the range is 0.75 to 1.00. Overall, the average benefit relativity factor for BCBSRI is 0.94 while at United, for medical benefits and prescription drug benefits combined, it is 0.85. United has clearly enrolled a greater proportion of groups and subscribers in plans with greater cost-sharing levels than has Blue Cross. It also appears that BCBSRI gives relatively less premium rate credit for cost sharing than does United. This was borne out when we asked each carrier to price the other's most common plan of benefits.

enroll in more comprehensive coverage, health status differences of the average member as well as benefit differences are taken into account. This practice is forbidden under R.I.G.L. 27-50.

It is interesting to note that only eight percent of United subscribers have a plan with a value of 1.00, while the majority have plans that range from 10% to 25% less expensive in terms of benefit value. In contrast, Blue Cross has 44% of its subscribers in the plan with the most comprehensive benefits, with less than 10% in plans as much as 10% less expensive, and none in plans that are significantly more than 10% less expensive in terms of the value of the benefits purchased.

United's most popular medical benefits plan has 29% of the groups (and 27% of subscribers) enrolled. Groups are far more concentrated within BCBSRI's top five benefit plans (membership drops from 46% of groups in the most popular plan to 7% of groups in the second most popular plan) than they are at United.

Some employers purchase more than one product, and their employees can choose among the multiple options offered. Most small employers (92% at United and 89% at BCBSRI) do not take advantage of this option; only one benefit plan is offered to employees at these groups.

D. The Components of a Health Insurance Rate

A carrier's base rate is the starting point for developing a rate for each small employer group, taking into account the allowed rate adjustments under the Act. The average of all small employer group rates is the adjusted community rate. The carrier needs a premium rate from the average subscriber to generate in the aggregate sufficient revenue to cover all expected claims, administrative expenses, distribution costs and reserve requirements (either profit or contribution to reserves) for its base plan of benefits for a specified effective date. The specific rate for each employer group is developed by adjusting the base rate for the specific plan, effective date, and the employer's demographic characteristics. (Potential rating adjustments are discussed in more detail under Rating Requirements.)

For rates effective November 2005, United's base rate for combined medical and prescription drug coverage for its HMO Choice products was approximately \$392. For BCBSRI, the base rate for its most popular products for the same effective date was

approximately \$399. These are the rates for benefit plans with a benefit relativity of 1.00. Accounting for the weighted average benefit relativities of each carrier's most popular plans, the average benefit-adjusted base rates are approximately \$338 for United and \$390 for Blue Cross. These rates are then further adjusted for health status and age/gender factors, as well as 4:1 compression. The difference in average health status factors across the two carriers widens the average difference between the rates for the most popular plans.

The carriers' base rates have changed over the past few years as follows:

Year	BCBSRI	Year	United
2002-2003	19%		
2003-2004	9%	2003-2004	16%
2004-2005	7%	2004-2005	9%
		2005-2006	13%

The change in base rate provides an indication of the increase in rates charged to employers.

The cost of health insurance can be separated into four major components—medical costs (also known as claims expense), administrative expenses, external distribution costs, and profit. A provision for premium taxes, if applicable, and an offset for investment income credit are also typically reflected in the rates.

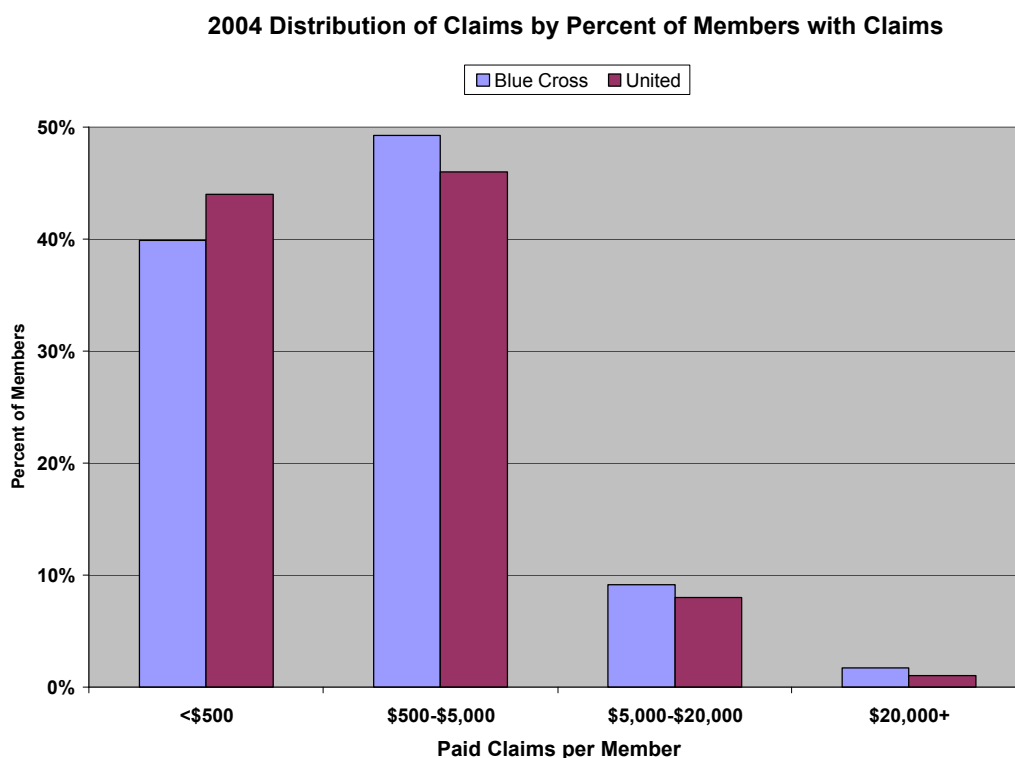
1. Claims Expense

By far the largest component of a health insurance premium is the medical cost. During the period covered by the examination, at Blue Cross, approximately 84% of total premium goes toward medical expenses, while at United approximately 78% of total premium was for medical costs.

The Effectiveness of the Small Employer Health Insurance Availability Act in Promoting Rate Stability, Product Availability, and Coverage Affordability

The average amount of claim payments for a small employer member of BCBSRI in 2004 was \$2,520. Based on a sample¹⁷, the average amount of claim payments for a United small employer member with at least some claims in 2004 was \$2,109. In addition to differences in the utilization of medical services, differences in plan design and provider payment levels have an impact on these claim payment levels.

For each carrier, the distribution of claims expense across the entire membership provides information about the risk profile of a carrier. The percentage of members with an annual claim amount of less than \$5,000 was similar for both carriers. Eighty-nine percent (89%) of BCBSRI members and 90% of United members had an annual claim amount under \$5,000. The following chart compares claim experience by percent of members with claims of various sizes across carriers.



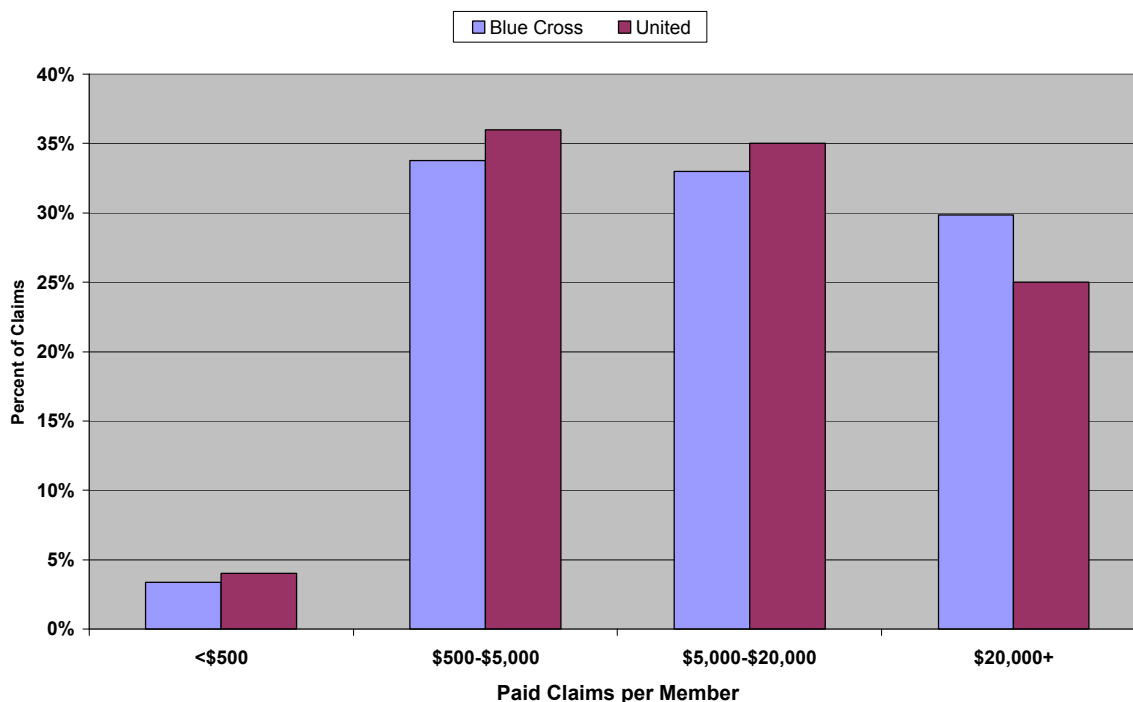
Note: United data based on a sample of claims, for members who had claims.

¹⁷ A sample was used because United did not provide all of its claim data.

The Effectiveness of the Small Employer Health Insurance Availability Act in Promoting Rate Stability, Product Availability, and Coverage Affordability

Based on the claim data provided by the carriers, it appears that BCBSRI has a substantially greater number of members with annual claims in excess of \$20,000. Thirty percent (30%) of BCBSRI small employer claim dollars are for members with annual claims of \$20,000 or more, while at United the comparable percentage is 25%. In the sample provided, United reported only two individuals with annual claim cost in 2004 that was in excess of \$100,000, representing 0.2% of United's total claim payments that year.¹⁸ Ninety-two members of BCBSRI had annual claim cost in excess of \$100,000 during 2004, representing 5.3% of BCBSRI small employer claims.

2004 Distribution of Claims by Percent of Claim Dollars Given a Claim



Note: United data based on a sample of claims, for members who had claims.

2. Loss Ratio

Loss ratios are generally taken as an indication of profitability in insurance. The loss ratio represents the percent of premium dollars paid out in medical claims. The

¹⁸ We should note again that United's claim data was based on a sample because they did not report all the claim data to the examiners. Blue Cross, on the other hand, provided all its claim data for 2004.

remaining dollars can be used to fund administrative expenses, external distribution costs, contributions to reserves (frequently considered profit for a non-profit organization), profit, external distribution costs, and any other non-claims related expenses. Thus, the lower the loss ratio the more money left over for non-claims expenses and profit.

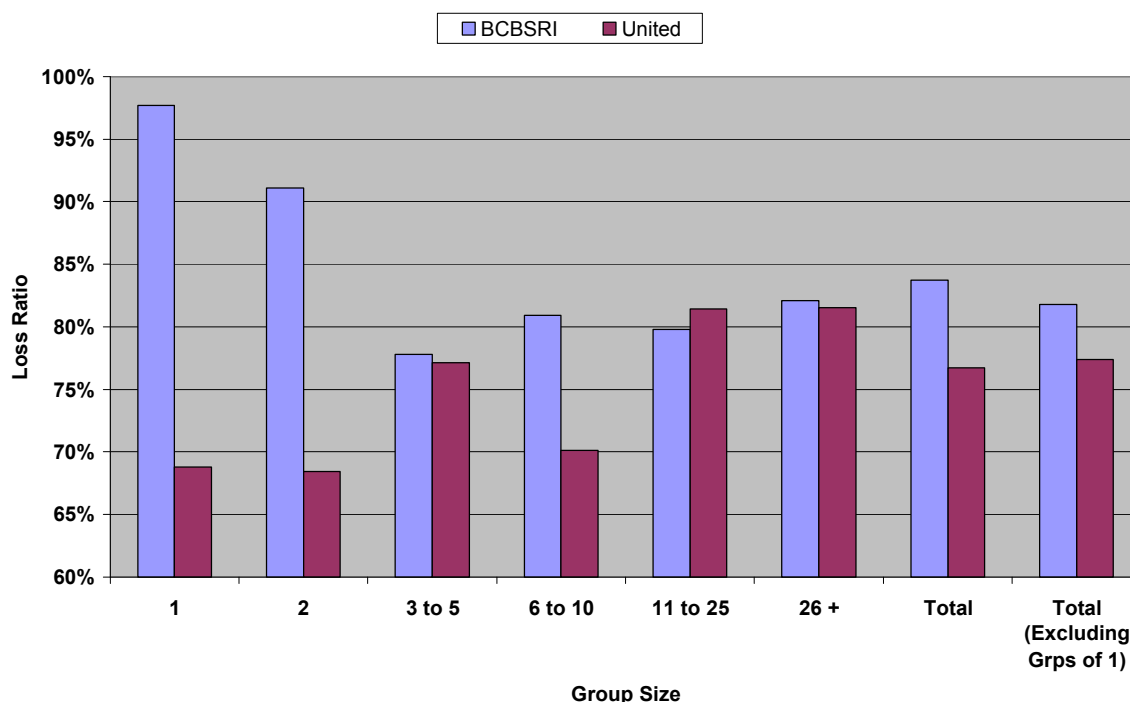
We looked at the overall average loss ratio for each carrier's small employer business. For the study period, the average loss ratio at BCBSRI was approximately 84%, although it varies by benefit plan. For United, during the study period, average loss ratio was approximately 77%.

One frequently presumed impact of rating all small employer business as one block (rather than separately rating different sized groups—e.g., groups of 1-5, 6-10, etc.) is that the larger groups subsidize the smaller groups. This is because larger groups are typically presumed to have better claims experience than the smaller groups because of selection issues. Additionally, larger groups are presumed to be more desirable because there may be some economies of scale in marketing, installing and administering a larger group. It has been presumed that the smallest groups have more knowledge about the health conditions of their employees, and are more likely to purchase health insurance based on projected need and in such instance, to purchase the most comprehensive coverage.

Blue Cross's loss ratios for groups with only one or two enrolled employees are higher than for any other group size segment. United, on the other hand, has relatively lower loss ratios for groups of one or two enrolled employees than for larger groups. It is important to note, however, that United did not start enrolling sole proprietors until October, 2004, so the loss ratio for groups of one may be lower than would be expected over time. For Blue Cross, the loss ratio for groups of three to five enrolled employees is the lowest of all size segments. The following chart indicates loss ratios by group size segment for United and BCBSRI.

The Effectiveness of the Small Employer Health Insurance Availability Act in Promoting Rate Stability, Product Availability, and Coverage Affordability

BCBSRI and United Loss Ratio by Group Size



Note: Data for United is as of each group's effective date during the year, for renewal business only. BCBSRI data is for enrolled contracts on 12/31/2004. It is important to note that United did not start to enroll sole proprietors until October, 2004.

If we exclude groups with one enrolled subscriber from the analysis, United's loss ratio would still be lower than that of BCBSRI.

3. Administrative Expenses and Contribution to Reserves

Administrative expenses include the cost of direct sales, marketing, enrolling members, billing, processing claims, medical management, provider contracting, network management, and all other services required to maintain and keep a carrier operational. As stated previously, approximately 84% of premium at Blue Cross and 77% of premium at United goes toward benefit payments. Expenses, too, are frequently discussed as a percent of premium. In 2004, at United, administrative expenses were approximately 12% of premium, based on an administrative agreement for an inter-company transfer of funds to United's parent, United HealthCare Services, for the Rhode Island based HMO. Based on our analysis, we estimate that United's

commissions and producer incentive payments are approximately 6% of premium¹⁹, leaving approximately 5% for contribution to reserves and profit.

At BCBSRI, approximately 11% of the premium is required for administrative expenses, 3% for commissions and producer incentive payments, and 2% for contribution to reserves (i.e., the company's retained earnings).

4. Distribution Systems and Costs

Distribution costs refer to the costs of marketing and selling a product. In this discussion, however, we are going to focus on external distribution costs. These are the costs paid by a carrier to producers and a general agent. Producers are licensed by the state of Rhode Island. In addition, payments are made to various Chambers of Commerce and the Rhode Island Builders Association for promoting BCBSRI health plans.

A producer's job is to represent the small employer, providing information and answering the employer's questions about products offered by carriers in the market. A producer is paid a commission (currently a fixed dollar amount per contract per month at both carriers) by the carrier as compensation for the work effort involved in assisting an employer to select and enroll in a health insurance product. We were advised during the course of the market conduct examinations that the carriers changed from a percentage commission basis to a fixed dollar amount in order to pay on a basis more consistent with the work effort (not paying more for older employees or higher cost plans, for example) and to avoid having commissions automatically increase in response to medical care cost inflation from year to year. In addition, both carriers pay bonuses, over and above the commission, to further reward producers who reach certain volume or persistency thresholds. Both BCBSRI and United build the cost of producer commissions and bonuses into the rates charged to all small employer groups.

¹⁹ United included some Massachusetts data in its commission database. Therefore, this number may be overstated.

In addition to producers, intermediaries²⁰ also market small employer coverage. For BCBSRI, in addition to selling and enrolling members, intermediaries also bill small employer groups and collect premium. Intermediaries forward the small employer's premium payments to BCBSRI on an agreed upon schedule. United uses intermediaries only as producers; United bills and collects premium directly for all its small employer groups. BCBSRI pays intermediaries a level of compensation that is greater than that paid to producers to reflect the additional work effort required of them. United pays intermediaries a commission that is the same as it pays all its producers. Compensation paid to intermediaries is reflected in the rates charged to all small employer groups.

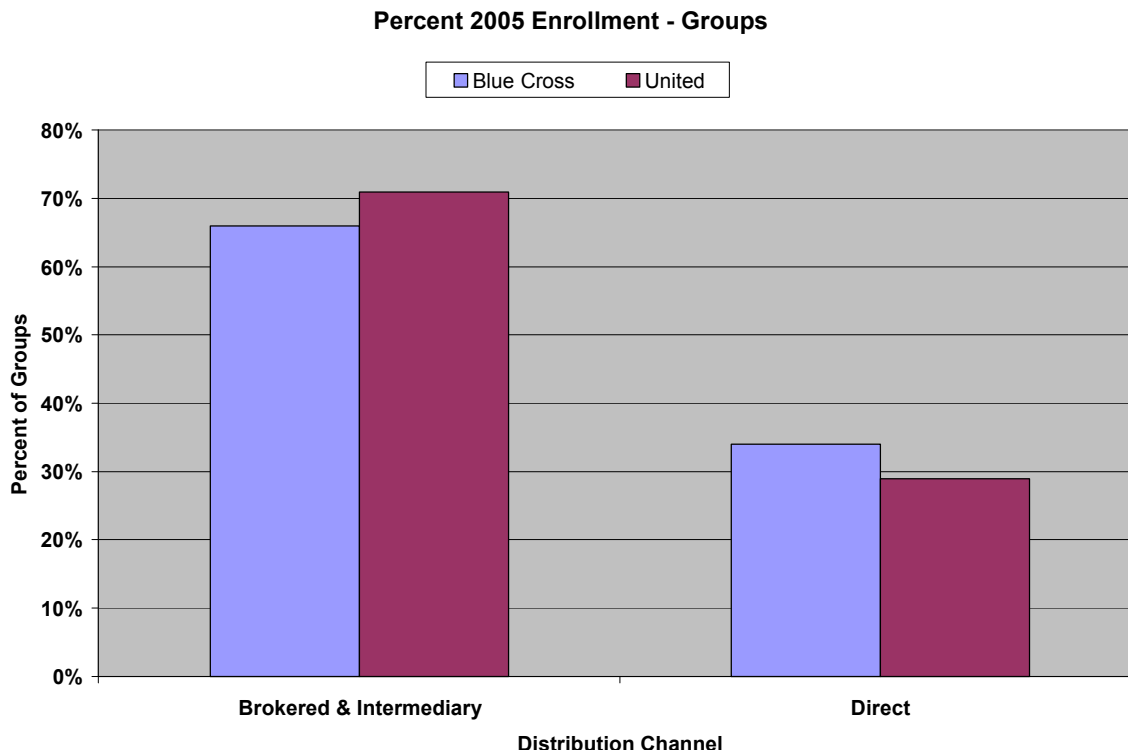
BCBSRI uses other external distribution channels as well—Chambers of Commerce and the Builders Association. The general agent assists BCBSRI in working with and managing the producers; the general agent does not directly sell coverage to employers. The various Chambers of Commerce and the Builders Association, however, promote insurance to their members on behalf of Blue Cross, either directly or through an intermediary or producer. BCBSRI provides compensation to its general agent, the Rhode Island Builders Association, and various Chambers of Commerce based on membership.

The majority of small employer group business at both carriers is sold through producers and intermediaries rather than by salespersons employed directly by the carriers. Neither carrier, in fact, actively promotes direct sales to small employers. Rather, each carrier has an internal sales staff which responds to in-coming calls from prospective clients. The business which comes in this manner is referred to as “direct” on the following charts.

As can be seen from the following chart, 66% of BCBSRI groups are represented by producers or intermediaries; 34% of groups are sold on a direct basis. At United, 71% of groups are represented by producers, with 29% sold on a direct basis.

²⁰ It is our understanding that Intermediaries are licensed to sell BCBSRI products.

The Effectiveness of the Small Employer Health Insurance Availability Act in Promoting Rate Stability, Product Availability, and Coverage Affordability

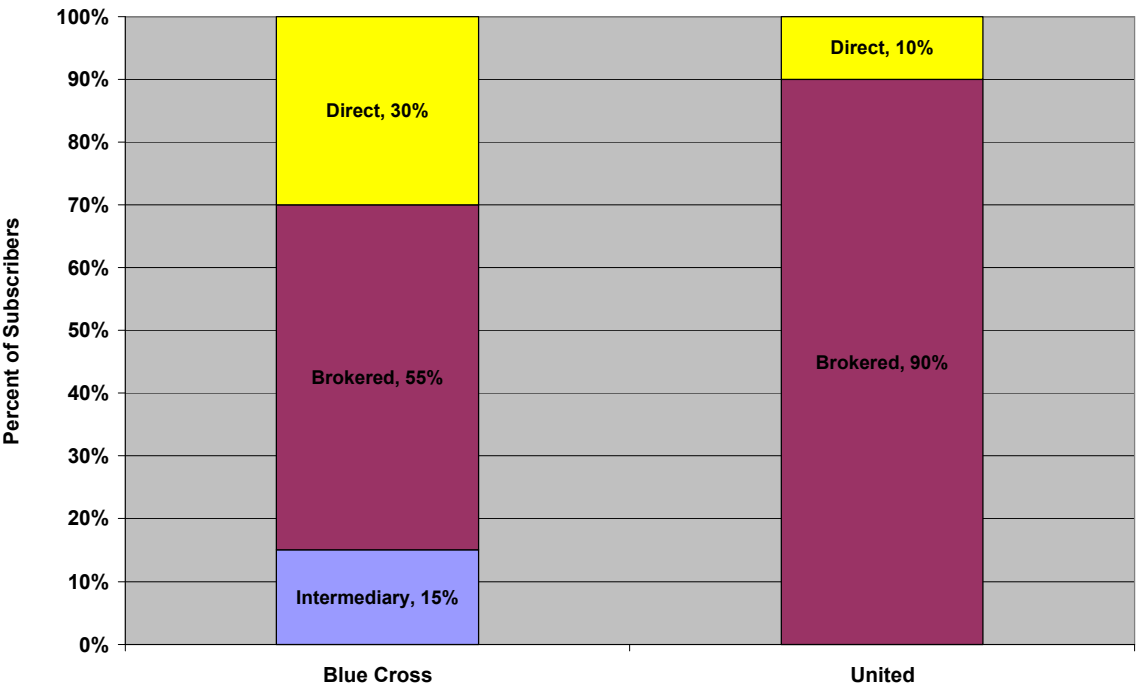


Note: United data is for renewal business only. United uses Intermediaries only in the role of producer.

Blue Cross currently limits the marketing activities of intermediaries to small employer groups of one to nine eligible employees. The average size of groups sold through intermediaries is 1.8 subscribers. At BCBSRI, the average size group sold through producers, other than intermediaries, has 5.9 subscribers. For groups sold on a direct basis, the average size is 3.4 subscribers. The average size group sold on a direct basis (renewal business only) by United has 1.9 subscribers, while the average size renewal group sold through producers has 6.9 subscribers. The following chart displays the percent of subscribers by distribution channel.

The Effectiveness of the Small Employer Health Insurance Availability Act in Promoting Rate Stability, Product Availability, and Coverage Affordability

Percent 2005 Enrollment by Distribution Channel

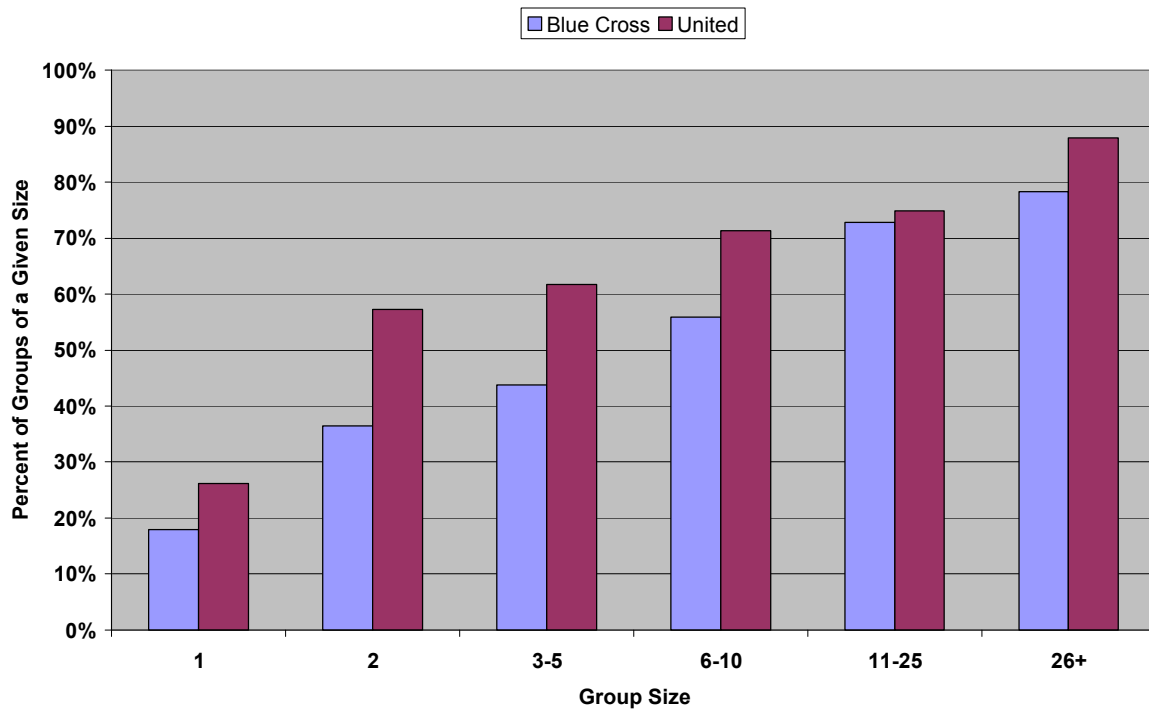


Note: United data is for renewal business only. United uses Intermediaries only in the role of producer.

Producers work with all size groups; however, as the size of the group increases, the percent of groups represented by producers increases at both carriers.

**The Effectiveness of the Small Employer Health Insurance Availability Act in Promoting Rate Stability,
Product Availability, and Coverage Affordability**

Percent of Brokered Groups by Size of Group -- 2005



Note: United data is renewal business only.

The most active producers, as defined by the level of commissions and bonuses received, tend to place business with both BCBSRI and United. A comparison of the rank of the top 10 BCBSRI producers or brokerages compared to their rank at United indicates that eight of BCBSRI's top ten broker(age)s are among United's top ten.

BCBSRI Rank	United Rank
1	2
2	5
3	4
4	9
5	1
6	8
7	6
8	3
9	41
10	12

**The Effectiveness of the Small Employer Health Insurance Availability Act in Promoting Rate Stability,
Product Availability, and Coverage Affordability**

There is more dispersion among the next ten BCBSRI producers or brokerages, as ranked by the level of commissions received for small employer business at BCBSRI:

BCBSRI Rank	United Rank
11	22
12	7
13	61
14	16
15	28
16	33
17	54
18	204
19	82
20	147

Looking at the United producers or brokerages ranked 11 to 20 reveals the following BCBSRI rankings (The “?” indicates that we were not able to locate the producer or brokerage’s name in the BCBSRI listings.):

United Rank	BCBSRI Rank
11	37
12	10
13	98
14	?
15	?
16	14
17	120
18	?
19	?
20	11

**The Effectiveness of the Small Employer Health Insurance Availability Act in Promoting Rate Stability,
Product Availability, and Coverage Affordability**

It is clear that the most successful producers in the Rhode Island market produce business for both Blue Cross and United, and that eight of the top ten for Blue Cross are also in United's top ten producer list.

A measure of producer concentration in the small employer market is the portion of total commissions that is earned by the top producers. At United, the top 7 broker(age)s accounted for 31% of commissions paid in 2005 while at BCBSRI the top 7 brokers (excluding intermediaries) accounted for 37% of commissions paid.

The number of producers with a significant amount of business at each carrier, as defined by a minimum of \$25,000 in annual small employer commissions, is less than 30 for both BCBSRI and United. The following table indicates the concentration of business among the brokerage community:

Number of Producers/Brokerages Paid Selected Levels of Commission, 2005

	BCBSRI		United ²¹	
	# of Producers	% of Total	# of Producers	% of Total
\$25,000 or more	27	60%	22	55%
\$5,000 to 24,499	105	27%	87	33%
Less than \$5,000	370	12%	272	12%
Total Producers or Brokerages	502		381	

²¹United included some Massachusetts data in its commission database. Therefore, this number may be overstated for Rhode Island alone.

**The Effectiveness of the Small Employer Health Insurance Availability Act in Promoting Rate Stability,
Product Availability, and Coverage Affordability**

In total, the level of external distribution costs in 2005 was as follows:

Type of Payment	Blue Cross*	United**
Producer Commissions	\$5,520,000	\$2,764,185
Intermediary Payments	1,740,000***	Included above
General Agent	2,450,000	Not applicable
Chambers Expense Allowance	60,000	Not applicable
Chambers Expense Direct Business	20,000	Not applicable
Builders Association Expense Allowance	100,000	Not applicable
Total Commissions and Intermediary payments	\$9,890,000	\$2,764,185
Bonuses	190,000	572,397
Total payments for external distribution system, including intermediaries	\$10,080,000	\$3,336,582
Bonuses as a % of Commission, based on producer commissions only	3.4%	20.7%

* From page 42 of the BCBSRI market conduct examination

**Based on Exhibit 5 of the United market conduct examination

***Approximately 86% of this is considered commission; the remainder is for additional services provided by Intermediaries to Blue Cross

The small employer community paid approximately \$13 million dollars in commissions and bonuses through its health insurance premium rates in 2005. The distribution of producer reimbursement between commission and bonuses is significantly different for each carrier, as illustrated by the following chart.

The Effectiveness of the Small Employer Health Insurance Availability Act in Promoting Rate Stability, Product Availability, and Coverage Affordability

Broker Commissions and Bonuses Paid in 2005



Amounts paid to producers as bonuses represent approximately 3% and 20% of commissions paid during 2005 for BCBSRI and United respectively.

United paid slightly over \$3.3 million in commissions and bonuses for 2005. This accounts for 6% of United's small employer premium rates.²² BCBSRI bonuses and commissions accounted for 3% of small employer premium rates that year. The total paid in 2005 by BCBSRI for commissions, bonuses, and other external marketing activities was approximately \$10 million.

E. Demographics—Age/Gender and Health Status

Both carriers use age, gender and health status in their rating formulas, as permitted by the Act.

²² United included some Massachusetts data in its commission database. Therefore, this number may be overstated.

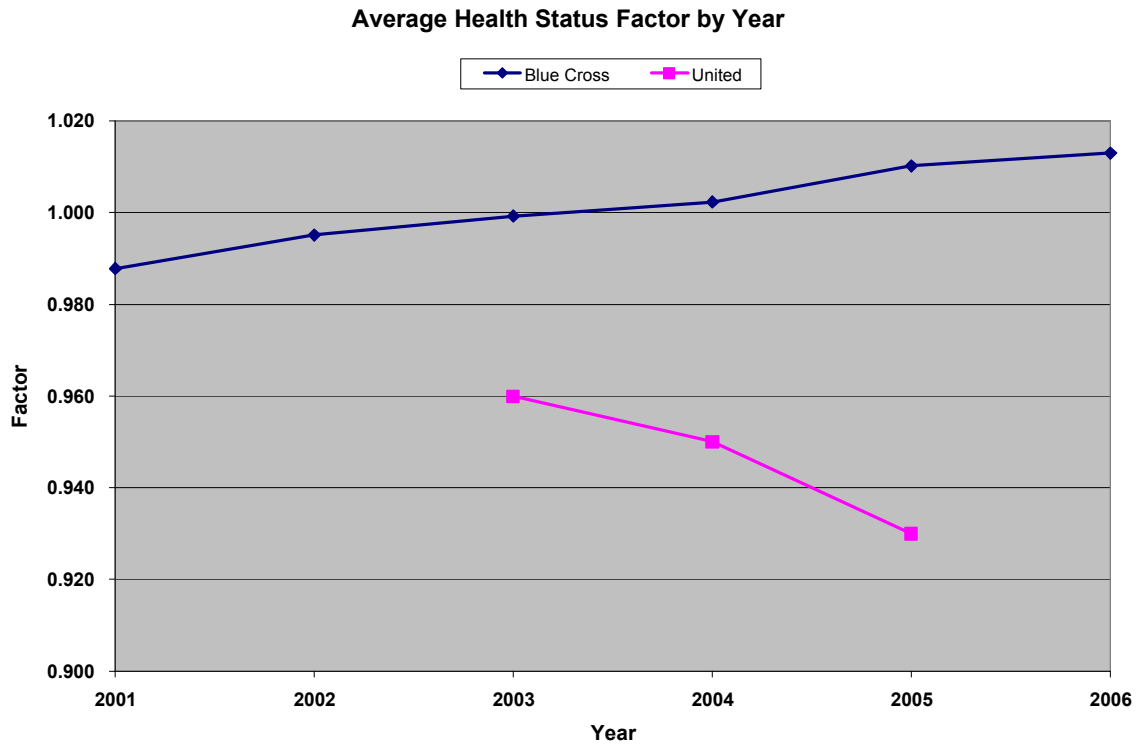
We did not receive sufficiently detailed data from United to make definitive statements about the relative age distribution within each carrier's pool of small employer membership. However, based on a sample, it appears that United's pool might be slightly older on average than that of Blue Cross.

With respect to health status, the two carriers both use a health status factor in their rating formulas. The health status factor is the result of a medical underwriting process. For new business, each carrier collects medical information from potential enrollees and/or employers. The information is analyzed, and an assessment of the expected health risk of each member is developed. This assessment is converted into a factor—the health status factor—for the entire group. For renewals, the health status factor is determined based on the claim history of members of the group using a methodology that varies by carrier and by size of the group.

The Act allows health status to impact the adjusted community rate by a factor of plus or minus 10%. Health status factors thus can range from 0.90 to 1.10.

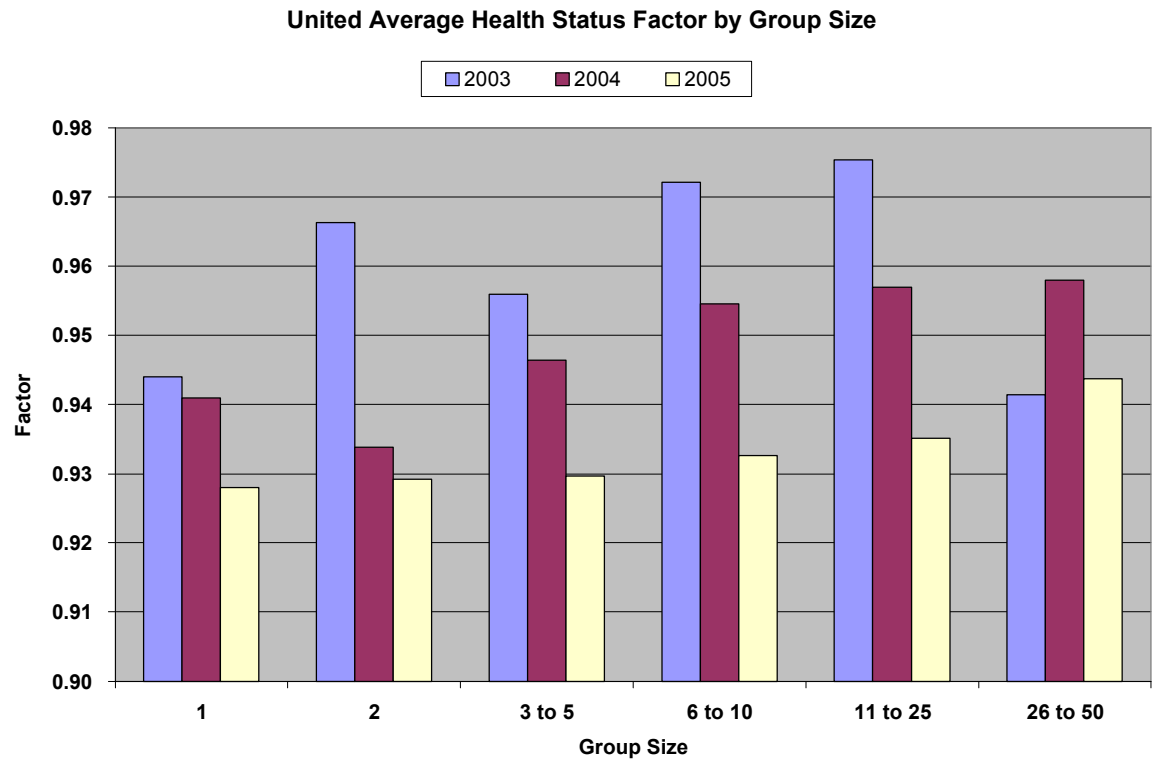
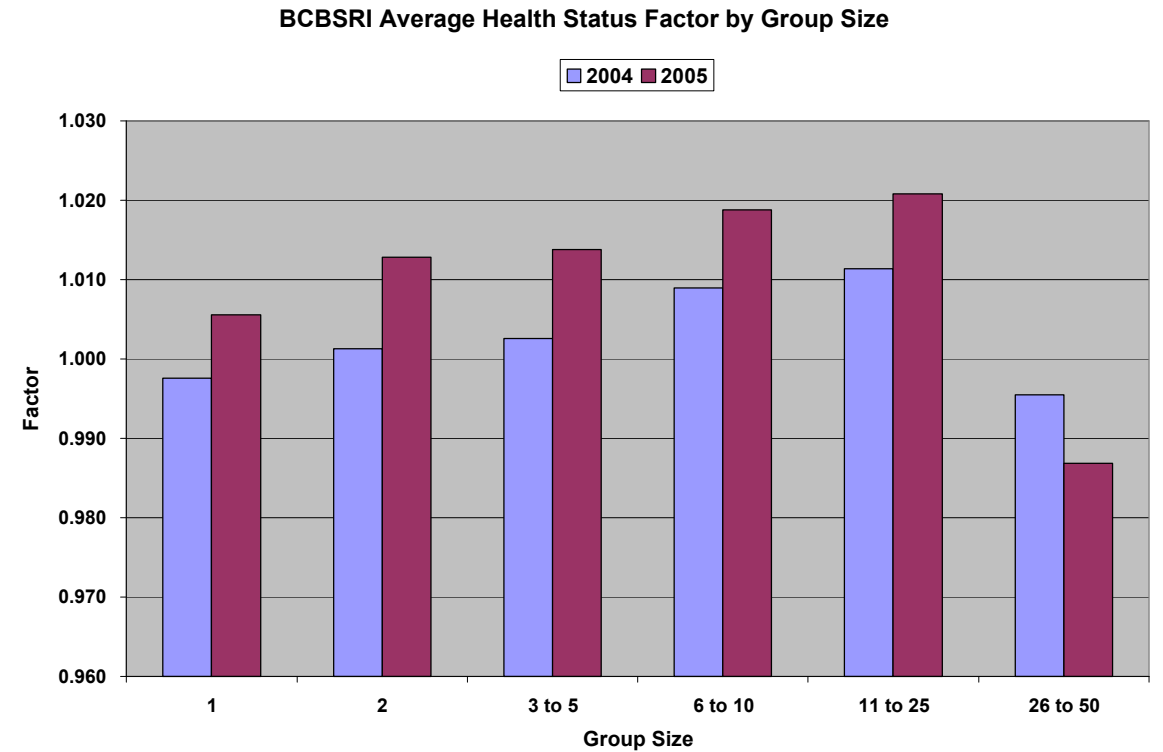
A comparison of health status factors over time provides an indication of the change, if any, in the overall health status of each carrier's population (or, at least, the carrier's measurement of that health status.) The following chart depicts the average health status factor over time at the two carriers. As can be seen in the chart, the average factor is gradually increasing at Blue Cross and decreasing, less gradually, at United. This change could be due to either a change in each carrier's evaluation of health risk or a true change in the health status of each carrier's members.

The Effectiveness of the Small Employer Health Insurance Availability Act in Promoting Rate Stability, Product Availability, and Coverage Affordability



It is also interesting to look at whether health status varies by size of group. The following two charts compare average health status factors by group size over time. At Blue Cross, the average health status factor increases slightly with group size until groups reach 26 or more, at which point it decreases. At United, the pattern is less regular.

The Effectiveness of the Small Employer Health Insurance Availability Act in Promoting Rate Stability, Product Availability, and Coverage Affordability



Note: United data is for renewal business only.

Also of note in the prior two charts is that United's health status factors center in the low 0.90s while BCBSRI's average health status factors hover closer to 1.0.²³

Particularly because there is such a difference between the carriers in their average health status factors, it is important to look at the distribution of health status factors across groups, as averages can hide interesting information. Each carrier uses different methods to develop their health status factors. The Act allows carriers to impact rates plus or minus ten percent due to the health status of a group. However, each carrier uses a different means of applying the results of their medical underwriting process. BCBSRI uses six absolute factors, with no factor lower than 0.92 while United uses a formula which generally results in one of the following values: .90, .95, 1.0, 1.05, and 1.10. As a result of a policy at United that limits the increases at renewal, it is possible that the health status factor is an intermediate value. (The data we obtained from United included a few cases outside these bounds because United appears to use the health status adjustment factor also as a way to implement 4:1 rate compression for some groups. The health status adjustment in United's database is therefore adjusted for some groups²⁴.)

In order to compare each carrier's ratings of the health status as applied to its own business, we need therefore to compare relative rankings within the 20% band permitted by the Act. We are using six categories; the absolute value of the factors in each category varies by carrier, and is detailed in the table below the chart.

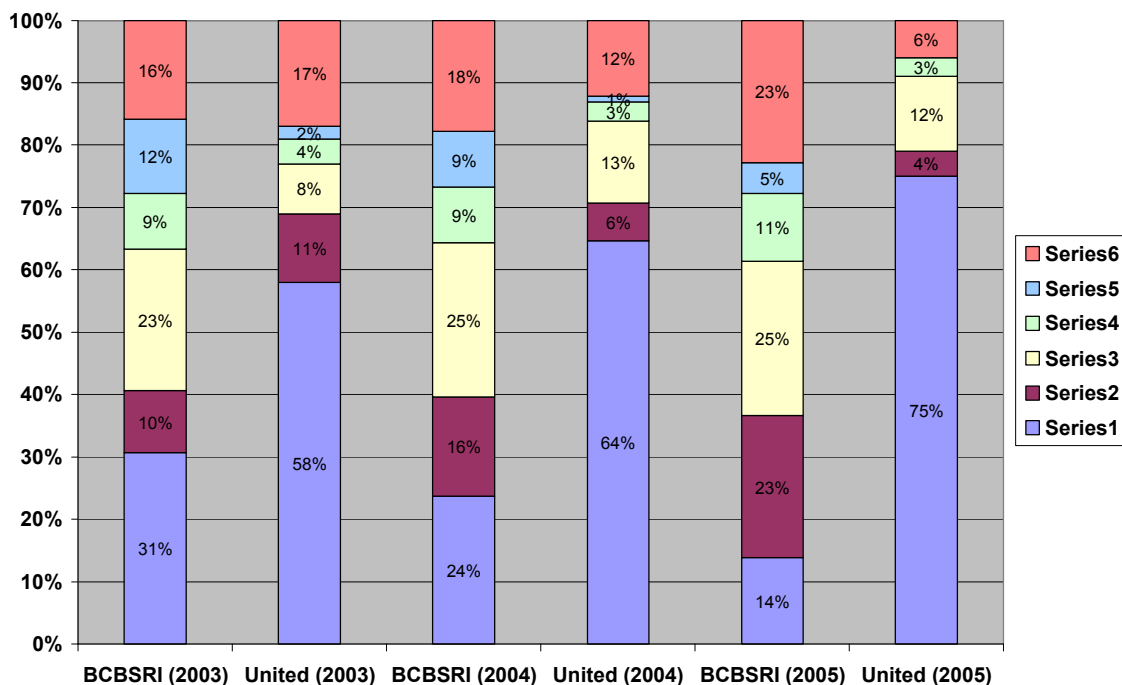
The following chart depicts the percent of groups at each carrier with various health status designations:

²³ The fact that United's health status factors average in the low 0.90s is the subject of a compliance recommendation. See Appendix B.

²⁴ The examiners did not receive an acceptable explanation for this.

**The Effectiveness of the Small Employer Health Insurance Availability Act in Promoting Rate Stability,
Product Availability, and Coverage Affordability**

Percent of Different Health Status Factors (2003-2005)



Note: United data is for renewal business only for 2003 and 2004.

Series Number	BCBSRI	United
1	0.92	<0.94
2	0.96	.94 -<.98
3	1.00	.98 - <1.02
4	1.04	1.02 -<1.055
5	1.07	1.055-<1.09
6	1.10	1.09+

As is indicated in the above table, United rated 58% of its groups in the lowest rated category in 2003; this increased to 75% of groups by 2005. BCBSRI was categorizing 31% of its groups in its healthiest category in 2003; by 2005, BCBSRI was categorizing 14% of its groups in its healthiest category.

BCBSRI rated 37% of its groups above 1.0 in 2003, 36% above 1.0 in 2004, and 39% above 1.0 in 2005. United, on the other hand, rated 23% of its groups 1.02 or above in 2003, 16% at that level in 2004, and only 9% at 1.02 or above in 2005.

It is important to note that at Blue Cross the impact of the health status factor on an average group is moderated by normalizing the overall impact for each quarter and for both carriers, it is moderated for a specific group by the impact of compression.

The changing distribution of health status factors at each carrier could be due to a number of different reasons. Medical underwriting is an inexact science, even though each carrier uses objective criteria to develop its factors. It is interesting to note, for example, that for groups which changed carriers, the new carrier generally evaluated the group at a lower health status factor than the old carrier, regardless of which way the group was going—from Blue Cross to United or from United to Blue Cross.

As mentioned earlier, the methodology used by United to develop health status factors is the subject of a compliance recommendation. United's methodology for determining health status factors may make United's rates less attractive to employers with higher expected claims levels.

The generally lower health status rankings at United could also be due to United's emphasis on lower cost benefit plans with more cost sharing. This product emphasis may have positioned United as the more attractive carrier for lower utilizers of care.

Carrier-Specific Compliance Issues

Carrier specific compliance issues are discussed in depth in each carrier-specific report, and the complete set of recommendations for each plan is included at the end of this report (Appendix A includes the recommendations for BCBSRI and Appendix B contains the recommendations for United.) For a detailed understanding of specific recommendations, please refer to the carrier-specific reports.

The recommendations included in the market conduct examination reports are important to achieving full compliance with the Act and the accompanying Regulation and need to be addressed by each carrier. The issues we have chosen to include in this narrative are those we believe to be most important from a market fairness and policy perspective.

A. BCBSRI

Compliance issues at BCBSRI are in general relatively minor. The majority of recommendations concerning the way BCBSRI conducts its small employer business have to do with improved documentation, some minor rate manual maintenance issues, disclosures to small employers, and the collection of information.

The one area of concern from a policy perspective with respect to BCBSRI has to do with the monitoring of third parties—the intermediaries. BCBSRI contracts with intermediaries to not only market and sell small employer business but also to bill groups, collect premiums, and forward premiums to BCBSRI on an agreed upon schedule. While researching an employee complaint as part of the market conduct examination, it became apparent that an Intermediary had charged a small employer a \$15 per employee per month fee. The basis for this fee was unclear from the documentation in the complaint and BCBSRI indicated that it had no knowledge of such activity and in fact the intermediaries were prohibited from assessing such fees contractually. The Regulation provides for a maximum \$5 fee per employee per month,

and only if such fee is charged uniformly to all groups. As a result of discussions between the examiners and Blue Cross during the market conduct examination, BCBSRI initiated an audit of its intermediaries in March, 2006. As a result of the audit, one intermediary was required by Blue Cross to refund fees improperly collected from small employer groups.

B. United

The market conduct examination report for United describes a number of concerns with respect to compliance. Of major concern is United's lack of response, or an incomplete response to various data requests. The lack of response prevented the examiners from determining compliance in a number of key areas. In particular, the examiners were not able to verify:

- a) the development of the base rates listed in the rate manual;
- b) case-specific age/gender calculations;
- c) the process for re-certification of small employer status;
- d) the age/sex factor for renewing cases;
- e) the development of the health plan relativities; or
- f) the appropriateness of the 12% inter-company administrative charge.

Thus, the examiners did not have sufficient data to determine United's compliance with multiple aspects of Chapter 27-50. Because United failed to provide requested information in certain instances and failed to provide complete information in others, the examiners were unable to conclude that United's rating practices are not abusive.

Based on the incomplete data provided, the examiners made recommendations to United with respect to improved documentation and rate manual maintenance. In addition, the examiners recommended areas where additional disclosure to small employers was required, as well as improvements to the accuracy and completeness of

marketing information that was provided in conjunction with the sales process and renewals.

Also of concern is United's approach to modifying the adjusted community rate for the health status of a group. The Act limits the impact health status may have on any group's rate to a 10% up or down adjustment to the adjusted community rate. However, the examiners concluded that United's health insurance adjustment factors result in a range of 3% below to 18% above the adjusted community rate. This results in charging certain small employer groups rates that exceed those allowed by the Act. The examiners estimate that approximately 9% of United's small employer groups were charged premiums that were higher than those allowed by the Act. United's methodology for assigning health status factors may also have resulted in less healthy groups not selecting United as their carrier and either not buying a health plan or buying a health plan from another carrier, because United's rates for less healthy groups would be quoted at up to 18% above the age/sex adjusted community rate rather than up to 10% above the age/sex adjusted community rate as required by the Act. This could ultimately lead to a concentration of the poorest risk groups at Blue Cross.

United is not in compliance with the Act's limit on pre-existing condition exclusions for products written under its insurance company license rather than the Rhode Island based HMO. Such exclusions are not permitted at all if the individual has prior creditable coverage. United is in compliance with this element. However, in the absence of prior creditable coverage, the Act limits such exclusions to six months for standard enrollment and twelve months for late entrants. United's time-frames are six months longer than the Act allows for both standard and late entrants.

Producer Survey Results

The original intent of the policy effort was to include a survey of all major stakeholders (producers, employers, legislators, executive branch staff, etc.) in the small employer health insurance market. However, given all the activity surrounding health insurance market reform in the state during the time of the examinations, it was decided that our survey should be focused solely on the operations of the small employer health insurance market, as well as the strengths and weaknesses of the small employer reform law. A survey of producers was deemed the best means of obtaining this information, since both carriers rely on producers to a significant extent for their sales and marketing efforts. The producer community is thus in an excellent position to understand the interests and concerns of small employers.

As a result, we invited ten producers to participate in a survey. We selected these ten individuals from a list of eighteen provided by OHIC. The ten represent high and medium performers, with all but one in at least one carrier's top twenty performers as determined by commission earnings. We completed seven interviews. Interviewees represented four of the top ten broker(age)s at each carrier (in some instances these are the same individuals), representing almost 24% of United's paid commissions and almost 29% of BCBSRI paid commissions. The questions we discussed with producers are included as Appendix D.

Since numerous policy discussions and proposals on small employer health insurance concern differences in behavior among groups of different size, the first question we asked producers was their perception of differences in small employer behavior by size. The majority of respondents felt that the type of business a group is in, rather than the employer's number of employees, has more impact on the product purchased and selected cost-sharing levels. Only two producers mentioned that smaller employers are more price-sensitive. In contrast, two producers mentioned that the smaller the employer, the more the employer is concerned about the welfare of the employees;

such employers generally select a rich benefit plan. With respect to product and carrier choice, producers generally felt that value for money was the key factor in any employer's decision making-process. This includes product design and price, since in Rhode Island the networks for the two major carriers are fairly similar. A number of producers also mentioned that eliminating coverage for certain mandates would be of interest to small employers and a good way to reduce rates.

In response to questions about their perception of the key factors affecting the cost of small employer health plans, producers mentioned most often the high levels of utilization and the older age of the Rhode Island population.²⁵

Because there is one dominant carrier in Rhode Island and only one other carrier with significant membership, an ongoing issue for discussion is whether or not it would be helpful to encourage additional carriers to enter the Rhode Island small employer market. We asked producers if they felt that an increase in competition for small employer business would result in decreased costs. The producers we spoke with were fairly evenly mixed in their impressions of the impact of increased competition. While some felt it would lead to lower prices in the short run, there was more skepticism of the impact in the longer term when carriers (both current and new) can no longer "buy business." In addition, multiple producers mentioned that an increase in the number of carriers would probably not have a short-term impact on what they perceived to be the major cost driver—over-utilization. A few individuals mentioned that one benefit of increased competition would be improved customer service. However, respondents also noted that the small size of the Rhode Island population probably would discourage new carriers from entering the market.

With respect to bringing new employers into the market, offering plans with more cost-sharing was the most frequently mentioned way to reach those employers who are not entering the market due to price. Non-price issues were also mentioned, however,

²⁵ Please refer to Appendix E for a discussion of utilization levels in Rhode Island.

including improved customer service. There is a sense that lack of competition leads to less customer-focused carrier behavior in Rhode Island than in other states.

Administrative requirements were also mentioned as impediments to bringing employer groups into the market. One producer mentioned that the more detailed individual enrollment requirements²⁶ for smaller groups (under twenty) steer some employers away from purchasing coverage as they do not want to burden their employees with such forms. There was also mention of employer fear of the certification process as a deterrent to coverage. (The certification process is the collection—both initially and on renewal—of information from each employee to be certain that all enrollees are actually eligible for coverage, and that the minimum participation requirements are met. OHIC recently provided guidance enabling carriers to recertify eligibility every two years rather than every year.)

One producer mentioned that the key determinant for the smallest small employer groups to enter the market is the health of the owner, and his/her need for coverage. Another mentioned that some employers will simply not purchase coverage regardless of price.

No interviewee thought streamlining the product portfolios of each carrier would be a problem in the marketplace so long as the process and resulting product portfolio were communicated well. Several producers mentioned that the multiplicity of products at each carrier resulted in confusion in the marketplace, as it is difficult to compare so many plans, even for them.

With respect to changes in the legislation and/or regulations, the following ideas were suggested:

- a) widening the allowed compression bands to bring additional people into the market;

²⁶ Both carriers require, as part of the underwriting process for groups with less than 20 employees, that individual employees to complete a health questionnaire.

The Effectiveness of the Small Employer Health Insurance Availability Act in Promoting Rate Stability, Product Availability, and Coverage Affordability

1. some producers felt that older and sicker groups wouldn't drop coverage as a result because they have no choice;
 2. others expressed concern that widening the bands might price the older and sicker groups out of the market;
- b) mandatory coverage was seen by two producers as the only way to get the younger, healthier people into the market;
 - c) mandated coverage for preventive and catastrophic care only;
 - d) products with increased deductibles and other cost-sharing so that they are more attractive to those who want lower premium costs;
 - e) maintain medical underwriting as a way to protect the rates of the younger and healthier groups;
 - f) provide a choice of family composition rates (e.g., two-tier or four-tier) to each group;
 - g) revise laws restricting competition to remove barriers to entry for new carriers to Rhode Island;
 - h) allow more flexibility in product design. In particular, catastrophic coverage (e.g., \$10,000 up-front deductible) and products without mandates were mentioned;
 - i) Allow non-smokers' discounts.

With respect to increasing the transparency of external distribution costs and producer commissions, no producer interviewed expressed a problem with increasing the transparency of distribution costs to clients.

We also asked interviewees about their sense of the ideal role for the state in small employer health coverage. More than one advocated mandatory coverage (perhaps at a

specified minimum benefit level) and/or employer assessments (or tax breaks for those employers who do offer coverage). Efforts to increase competition and/or ensure all carriers are on an equal playing field were also suggested. Education of employers and consumers to allow them to better manage their health care costs was another potential role for the state raised by a few producers. One producer went so far as to suggest that the state maintain a database related to the utilization of certain high cost services (pharmacy and radiology) to help carriers manage health care costs.

Overall Issues of Concern and Resulting Policy Recommendations

Data was collected in conjunction with the carrier-specific market conduct examinations to support an overall assessment of the effectiveness of the Act and Regulations and, if appropriate, to recommend changes that would result in greater effectiveness of the Act. In addition to an analysis of this data and other information gleaned from the examinations, we discussed with both carriers' staff their concerns and ideas for change. We reviewed national data and the literature with respect to small employer reform efforts in other states, discussed potential changes with representatives of the producer community, and discussed initial ideas with OHIC and RIteShare leadership. We also shared our ideas for change with the carriers and solicited their feedback.

As a result, we have developed a series of recommendations, some focused specifically on the statute itself and others focused more broadly on the area of the affordability of small employer health coverage. We were specifically asked to look at publicly available data on the major cost drivers in the health insurance marketplace in Rhode Island. Appendix E discusses this issue.

One ongoing discussion in health policy circles is the relative benefits of each of two competing and potentially mutually exclusive goals: (a) providing affordable coverage to as many employers and employees as possible and (b) providing affordable coverage to the oldest and/or sickest in the population. The degree to which these goals are mutually exclusive depends upon the degree to which the healthy subsidize the sick.

Another factor to consider is the impact of the uninsured on the financial stability of the health care provider system. If the sickest individuals opt out of coverage because their insurance rates are no longer affordable, the potential for unpaid provider bills in the short term increases. For each unhealthy individual who leaves the insurance market, the probable, potential level of provider bad debt and/or free care is greater than for

each healthy individual who does not enter the insurance market. Over the long term, as more unhealthy individuals drop coverage, provider bad debt and free care will be built into the rates paid by the remaining insured population. This exacerbates the affordability issue for the healthier people remaining in or hoping to join the insurance pool.

Our recommendations are made with these potential conflicts in mind, and are based on the belief that the purposes of Chapter 27-50, continue to be the goals that small employer health reform efforts in Rhode Island are meant to achieve. To reiterate, the key purposes of Ch. 27-50 are to:

- Enhance the availability of health insurance coverage to small employers regardless of their health status or claims experience;
- Prevent abusive rating practices;
- Prevent segmentation of the health insurance market based upon health risk;
- Spread health insurance risk more broadly;
- Require disclosure of rating practices to purchasers;
- Establish rules regarding renewability of coverage;
- Limit the use of preexisting condition exclusions; and to
- Improve the overall fairness and efficiency of the small group health insurance market.

With respect to the regulation of small employer health coverage, our major areas of concern, and areas in which we have suggestions for change (or comments encouraging the maintenance of the status quo), are:

- A. Managing Groups by Size, Particularly Groups of One Subscriber
- B. Product Portfolio

- C. Distribution System
- D. Rating Requirements
- E. Additional Protections for More Even Risk Distribution
- F. Impacting the Cost of Care

Our key recommendations are as follows:

- A. Managing Groups by Size, Particularly Groups of One Subscriber
 - 1) Require each carrier to maintain its small employer pool, including groups of one eligible employee, as one block of business for rating purposes.
 - 2) Study the potential for merging the small employer and Direct Pay rating pools
- B. Product Portfolio
 - 1) Encourage each carrier to streamline its product portfolios, subject to OHIC approval of the process
 - 2) Enable carriers to provide information about selected products to prospects and on renewal, subject to OHIC approved criteria.
 - 3) Develop and maintain a website and Speakers Bureau to educate employer groups about small employer health insurance coverage; OHIC to develop materials as well.
- C. Distribution System
 - 1) Eliminate volume and/or persistency-based bonuses

- 2) Require carriers to work only with producers that disclose to clients the projected annual commission amount which the broker(age) will receive for placing the client's business
- 3) Require all carriers to file commission schedules with OHIC
- 4) Require carriers to itemize external distribution costs in proposals and renewals given to employers
- 5) For the longer term, discuss with the producer and carrier community the following:
 - i. Adding external distribution costs as a rating variable not subject to compression and
 - ii. Having producers bill clients directly

D. Rating Requirements

- 1) Maintain the current rating methodology, including the currently permitted rating variables and 4:1 compression, for groups of all sizes
- 2) Prohibit List Billing
- 3) Consider the establishment of a minimum loss ratio requirement

E. Additional Protections for More Even Risk Distribution

- 1) Study the appropriateness and effect of implementing risk adjusters should the need arise in the future

- 2) Prohibit Third Party Administrators (TPA)s from selling ASO business to small employer groups²⁷
- 3) Periodically review the need for a filing requirement for small employer rates
- 4) Develop and require the use of standardized data collection tools for the collection of employee and dependent medical information by the carrier to be used in developing health status factors
- 5) Eliminate the requirement for employee eligibility certification after initial enrollment; carriers shall be permitted to recertify groups at their own discretion
- 6) Revise the annual carrier reports to OHIC so that OHIC receives information which will be useful in monitoring changes in the marketplace
- 7) Require carriers new to the market to notify OHIC when the carrier's first quotation is issued to a Rhode Island small employer

F. Impacting the Cost of Care

- 1) Require carriers to report their medical management efforts to OHIC; subsequent to this, carriers and OHIC should jointly devise improvement goals for the small employer population
- 2) All parties work with DOH to explore appropriate improvements to utilization management regulations

²⁷ Should this not be possible, we would recommend protecting small employers by requiring extremely low levels of stop loss to be purchased together with ASO business.

- 3) Eliminate the ability for patients to over-ride a physician's determination that a pharmacist may substitute a generic medication in place of a brand name drug
- 4) Require carriers to provide RlteShare with timely benefit plan information
- 5) Require carriers to notify RlteShare when employees are terminated from small employer coverage
- 6) Revise the Rhode Island Extended Medical Benefits eligibility requirements to add all COBRA eligibility provisions (e.g., voluntary termination)

We discuss each area in turn, and provide the rationale for the recommendations.

A. Managing Groups by Size, Particularly Groups of One Subscriber

1. Segmenting the Small Employer Pool by Size

Two of the purposes of the Act, and two key results of community rating, are to “prevent segmentation of the health insurance market based upon health risk” and to “spread health insurance risk more broadly.”

Currently, small employer groups of size 1 to 50 are rated as one large pool. The experience of all groups, regardless of size, is combined. Both carriers and the majority of the producers who were interviewed suggested that segmenting this total pool into multiple, smaller rating pools by size of group would be beneficial. This suggestion is based on the belief that smaller segments will more accurately apportion costs (both claims costs and administrative costs) to those that incur the expense. Greater segmentation of the market would allow a carrier to match more closely the premium rates charged a specific employer group to the cost of healthcare services and administration for that group. The carriers and producers who suggest this further segmentation of the market believe that such an approach will help attract younger and

healthier groups, since they will not be subsidizing the older and less healthy groups to the same extent as they currently do.

It is true that if risk pools are defined more narrowly, a group's rate will reflect more closely its own experience. If this approach is taken to the extreme, every group would simply pay its own claims directly. Very large employers operate this way when they are fully experience rated or when they purchase administrative services only (with or without catastrophic reinsurance) from a carrier. In a small group, though, this is extremely risky as total experience can be dramatically impacted by one catastrophic case, and costs could vary significantly from one year to the next.

The purpose of insurance is to pool risk. The larger the risk pool, the more groups and subscribers across which a carrier can spread expected risk. Segmentation of the market decreases the number of subscribers who share risk and thus decreases the credibility of the pools. In addition, the Act permits certain adjustments to the overall, projected pooled experience. The permitted adjustments are age, gender, and health status of the group, subject to 4:1 compression.

Segmenting the small employer pool into smaller subsets by size of group would be directly contrary to the two goals of the Act stated above—to “spread health insurance risk more broadly” and to “prevent segmentation of the health insurance market based upon health risk.”

Segmenting the small employer pool would also be contrary to the goal of “enhancing the availability of health insurance coverage to small employers regardless of their health status or claims experience.” This is because the larger the pool used for rating purposes, the less one particular employer's claims experience impacts its own rate.

Data collected during the market conduct examinations bears out these points. Based on the small employers that are current ensured by BCBSRI, the pool for which we have the data to be able to calculate this, separating out groups of 1-5 subscribers could result in a rate for these groups which is 5% higher than the rate for the remainder of the groups, all else remaining constant.

Another way to look at this, using loss ratio data, is that BCBSRI groups of 1-5 would experience a 3% increase from being rated separately, all else remaining constant, and rates for the larger small employer groups could be reduced by 2%. (Should rates for the larger groups not be reduced, overall profitability would increase.) It appears that United's loss ratio on its smallest groups has been more favorable than for larger groups, based on data from United's market conduct examination. This would imply the possibility of a lower rate for the smallest groups.

There are other considerations as well. Smaller employers are frequently more economically marginal than larger ones; an additional rate increase due solely to size may lead some employers to drop coverage or to refrain from seeking coverage in the first place.

In addition, multiple pools increase the administrative complexity facing the carrier in enrolling and rating small employer business. As rules change by size of group, accurate monitoring of group size increases in importance. Carriers currently find the small employer certification requirements administratively burdensome. The burden would only increase as additional size requirements are tied to rates. There would also be disruptions to the groups themselves as they changed size categories, with a resulting health insurance rate impact.

The suggestion to segment the small employer pool into multiple blocks based on the size of the group for rating purposes is not one that we support. There are other means of segmenting a health insurance risk pool—e.g., geography, industry, administrative costs and health risk. These approaches were not suggested by either carrier, and we do not recommend them.

Maintaining the small employer pool as one block of business for rating purposes enhances the goals of maintaining access to coverage for the smallest groups, preventing segmentation of the health insurance market based upon health risk, and spreading health insurance risk more broadly.

2. Treatment of Groups of One Subscriber ²⁸

Groups with one eligible employee, including self-employed individuals, are small employers under Rhode Island law. In many states, however, an employer must have at least two eligible employees to be eligible for the protections of laws relating to small employer health insurance.

There are currently two main options for self-employed sole proprietors in Rhode Island when purchasing health insurance—they can choose to purchase coverage in the small employer market or they can choose to purchase Direct Pay coverage. Direct Pay coverage is offered only by BCBSRI, and is available to individuals under age 65 who are not working or who are not eligible to obtain insurance through an employer. It is our understanding that BCBSRI will not issue a Direct Pay policy if an employer intends to contribute towards the Direct Pay premium or if an individual has access to an employer-sponsored plan. The exception to this is sole proprietors. In addition, it appears that some self-employed individuals have obtained coverage from MEGA through its association plans. The market conduct examination of MEGA is not yet complete, however, and we currently do not have information to evaluate completely the effect of MEGA on the market.

Groups of one (whether sole proprietors or others who do not obtain health insurance through an employer group) are typically thought to be poorer actuarial risks than larger groups, even within the small employer market, not because such individuals are inherently unhealthy, but because of the opportunity for selection. The reason for this is that the individual deciding to purchase coverage has some idea of whether or not he or

²⁸ For the purposes of this discussion we are considering groups of one subscriber to be self-employed individuals. Insured groups consisting of one enrolled individual out of two or more eligible individuals are not addressed in this narrative. This latter group consists of employers where all but one employee either waives or declines coverage. Our policy discussion does not include these groups as it is likely that those groups' eligibility for small employer coverage could fluctuate over time based on the presence or absence of employees' waiver status.

However, it is important to note that the data analysis in this section is based on groups of one subscriber, whether or not there are other eligible employed individuals who chose not to enroll in the employer's coverage. This is because the data we obtained does not include the total number of eligible employees, only the number of enrolled subscribers.

she might need medical care in the foreseeable future. The thinking is—those who expect to incur medical expenses purchase coverage, and purchase the most comprehensive coverage they can afford. Those who do not believe they will need to use the coverage do not purchase it, or if they do purchase it, they buy lower cost coverage with more cost sharing. This results in adverse selection. The adverse selection is encouraged by the fact that coverage is available from both carriers on a guaranteed issue basis without any pre-existing condition exclusions for most products. The more individuals there are in a group, even a small group, the less likely it is that the decision-maker (the employer) has information about both the short and long term medical needs of the group's members. Also, the larger the group, the less likely it may be that one individual's medical needs (other than the owner's needs) would influence the decision to purchase coverage for the group as a whole.

The loss ratio experience included in the Loss Ratio section of this report bears out this hypothesis for the BCBSRI small employer book of business. BCBSRI's highest loss ratios are for its groups of one enrolled subscriber. Loss ratios this high suggest that groups with one subscriber are subsidized by larger small employer groups.

The situation at United, however, is different. United's loss ratio experience for its groups of one enrolled subscriber is quite favorable. We suspect that United's medical history questionnaire, non-compliant health status factor calculations, and the fact that they only started enrolling groups with one eligible employee in October, 2004 may have contributed to this difference in the experience of the smallest groups, in comparison to BCBSRI. In addition, the fact that United emphasizes lower cost benefit plans, with more cost-sharing, while BCBSRI is known for its comprehensive coverage may indicate that Blue Cross is more appealing to the smallest employers if they anticipate being high utilizers, and that United is more appealing to small employers who are cost conscious and who expect not to be high utilizers.

Policy options for coverage for groups of one are to:

1. Eliminate sole proprietors from the definition of small employer;
2. Merge the small employer and Direct Pay pools; or
3. Maintain the status quo.

We will discuss each of these options in turn:

1. Eliminate sole proprietors from the definition of small employer:

Because groups of one are typically seen to be poorer risks than other small employer groups, one option for moderating small employer rates as a whole is to require all groups with only one employee to purchase Direct Pay coverage. Modeling this proposal based on 2004 BCBSRI small employer experience, eliminating groups with one enrolled subscriber would result in small employer rates for the remaining BCBSRI small employers (group size 2 to 50) decreasing by 2.2%. At United, groups of one currently experience the lowest loss ratio, so eliminating groups of one, if profitability levels are to be maintained, would lead to an increase for all other groups.

This potential for a slight decrease in rates for the small employer pool at Blue Cross needs to be balanced against the impact on the groups of one employee forced to leave small group. Over 30% of the groups in each major carrier are groups of one subscriber. Using 2005 data, over 6000 groups (10% of total subscribers) would potentially be affected. (However, this data includes both sole proprietors and groups of one subscriber, regardless of the size of the employer, so these numbers are overstated to an unknown extent.)

**The Effectiveness of the Small Employer Health Insurance Availability Act in Promoting Rate Stability,
Product Availability, and Coverage Affordability**

	Groups of One Enrolled Employee, 2005 Snapshot	Total Subscribers	Percent of Subscribers
BCBSRI	5,222	46,596	11%
United	801	13,222	6%
Total	6,023	59,818	10%

If sole proprietors were eliminated from the small employer definition, instead of a choice of carriers, sole proprietors would need to purchase coverage from BCBSRI. United is not currently in the Direct Pay market and there is no guarantee that it would enter this market unless required to do so as a condition of staying in the small employer market.

In addition to a reduced choice of carriers, groups of one would also have a reduced choice of products if the BCBSRI Direct Pay products were the only health plan options that were available. BCBSRI Direct Pay benefit plans were changed in April, 2006 and currently first dollar, comprehensive coverage is not available. Four products, all with up front deductibles, are currently available to Direct Pay subscribers. Forcing sole proprietors into Direct Pay coverage would therefore result in a decrease in coverage for most people. Allowing such groups to remain as small employers enables them to either maintain their current level of benefits or purchase coverage with greater cost sharing in the future.

In addition, subscribers who belong to a group of one eligible employee may choose to not purchase Direct Pay coverage if they are no longer eligible to purchase small employer coverage. This would result in an increase in the number of uninsured in Rhode Island.

Adding 6,000 subscribers to the Direct Pay market would have a substantial effect on that market, increasing the size by over 60%. This would create the need for a complex analysis of the rating implications, and potentially significant dislocation to current Direct

Pay members and current small employer groups of one in terms of the products available and the rates they would pay.

For the above reasons we do not support the proposal to remove sole proprietors from the definition of small employer.

2. Merge the small employer and Direct Pay pools

Adding the Direct Pay population to the small employer pool is another potential option.²⁹ In addition to sole proprietors, this would impact the purchasing choices of all persons who are eligible for Direct Pay. In order to understand the implications of this proposal, a short description of the Direct Pay population and enrollment requirements is in order.

There are two different ways to join the Direct Pay population, each with its own rating structure and eligibility requirements. The two populations are referred to as Pool I and Pool II. Membership in Pool I is on a guaranteed issue basis—no one can be refused coverage. Pool I coverage is available to individuals and families who are unable to satisfy the medical underwriting requirements for Pool II due to their medical history. That is, they have existing health conditions which indicate that they can be expected to incur more claims than are anticipated in the rates applicable to Pool II subscribers.³⁰ Access to Pool I is available during an annual open enrollment period and, on an ongoing basis, to individuals who can demonstrate continuous coverage according to HIPAA guidelines. In 2005, the open enrollment period was one month long.

Pool II is available to individuals and families whose responses to the Direct Pay medical questionnaire and whose claims history, if available, does not indicate any ongoing medical conditions significant enough to warrant the applicant to be considered

²⁹ Massachusetts recently called for a study to assist in implementing such a change in the future. One key difference, however, is that in Massachusetts all carriers with a certain number of small employer lives are currently required to sell Direct Pay coverage.

³⁰ In small employer coverage, the rates for these individuals would be adjusted by a health status factor. Direct Pay does not use health status factors. It uses the two Pools to account for differences in health risks.

ineligible for Pool II. Once admitted to Pool II, an individual maintains his or her Pool II status regardless of subsequent health status or utilization.

Pool II rates, applicable to individuals and families who pass medical underwriting, are age and gender adjusted. Pool I rates are set at approximately the maximum level for Pool II and do not vary by age or gender. Every Pool I subscriber pays the same rate for a given benefit plan and contract type. The level of benefits for a given health plan does not vary between Pool I and Pool II.

Working individuals are typically considered to be better actuarial risks than those who are not working, because a certain level of health is necessary in order to be able to work full time. Whereas groups of one subscriber may be considered the poorest risks in small employer coverage, individuals enrolled in Direct Pay are typically considered even poorer actuarial risks—for some individuals the reason they are not working may be related to health concerns. Thus, the addition of Direct Pay members to the small employer pool can be expected to worsen expected claims experience, leading to an overall increase in small employer rates.

This presumption is borne out by the BCBSRI data. The experience of the Direct Pay population, adjusting for age and benefits, and combining Pool I and Pool II, is about 8-10% worse than BCBSRI small employer experience.

In order to better understand this difference, we need to consider both the claim amounts paid by the carrier and the cost sharing amounts paid by the member because the level of cost sharing is typically higher under Direct Pay than it is in small group. The sum of BCBSRI paid claims and subscriber cost sharing is 30% higher for Direct Pay subscribers than for small employer subscribers. The effect of the age distribution accounts for approximately 22% of this difference. Higher utilization of services, reflecting the net effect of more unfavorable health status offset by the deterrent effect of higher relative cost sharing, account for the remaining 8% of increased cost for Direct Pay compared to small employer coverage.

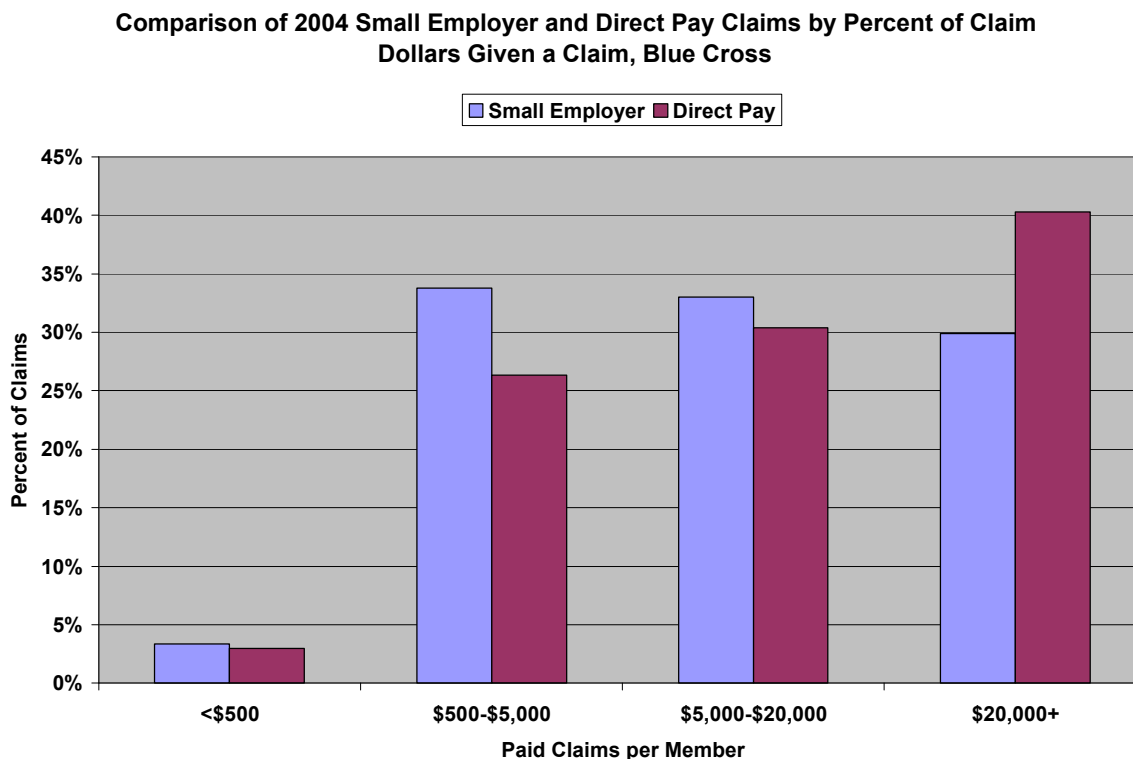
Moving the current Direct Pay population into the BCBSRI small employer pool, prior to the consideration of any additional selection issues, would result in a 1-1.5% increase for the overall small employer pool. This may be offset somewhat by a decrease in the percent of groups which use producers and generate commission payments, as the Direct Pay population currently purchases its coverage without the assistance of producers. This decrease in the percent of groups incurring commissions would result in less than a 0.5% decrease in overall rates, due solely to a lack of commissions; the downward adjustment may disappear over time if former Direct Pay members seek the help of producers when selecting a small employer carrier and plan.

There are other differences in the rating methodologies which impact the comparison of Direct Pay rates to small employer rates. The slope of the rates by age is different. Also, small employer products have four contract types—employee, employee plus child(ren), employee plus spouse, and family. Direct Pay has only two contract types—individual and family. Since Direct Pay family rates are for a composite of employee and spouse, employee and child and full family subscribers, Direct Pay family rates are relatively lower compared to individual rates than they are for small employer rates. At the same time, some families may be paying the family rate in Direct Pay whereas under small employer rules they might be eligible for a relatively less expensive contract type.

Direct Pay subscribers are generally older than small employer subscribers. In 2005, when calculated on the same scale, the average age/gender factor for Direct Pay subscribers was 122% of that for small employer subscribers.

The portion of claims paid for members who incur annual claim costs in excess of \$20,000 is greater for the Direct Pay population than in BCBSRI's small employer population, as illustrated in the following chart.

**The Effectiveness of the Small Employer Health Insurance Availability Act in Promoting Rate Stability,
Product Availability, and Coverage Affordability**



This is an indication of the distribution of high cost cases across the two populations, with Direct Pay having 70% of its claim dollars going to members with annual claims of \$5,000 and above and the Blue Cross small employer pool having 66% of its claim dollars going to such cases. The difference is greater when you look at just the highest cost cases—Direct Pay spends 40% of its claim dollars on members with claims over \$20,000 while for the BCBSRI small employer population the comparable percent is 30%.

Because of differences in the age and gender table structure used for rating the small employer and Direct Pay business, some people eligible for small employer insurance may be able to buy Direct Pay more cheaply than comparable small employer health plans. On a benefits adjusted basis, Pool II rates are significantly lower than small employer rates at the higher ages and for all female age categories. Small employer rates are generally less than Pool I rates, except for the highest age groupings.

If Direct Pay were merged with the small employer market, current Direct Pay eligible consumers would benefit from access to a wider range of insurance products, including United's products. United has not been an insurer for this (Direct Pay) market segment but would become an option for the former Direct Pay subscribers if they were merged into the small employer market.

However, combining the pools may result in some adverse selection due to the elimination of the open enrollment period (there is continuous open enrollment in the small employer market) and the availability of richer benefit plans. Total health insurance enrollment, however, might increase, as those who cannot pass medical underwriting would no longer have to wait for an open enrollment period to obtain coverage. Potentially offsetting this benefit is the fact that healthier individuals may now postpone enrollment because they know that, if they do develop the need for coverage, they would not need to wait for an open enrollment to obtain coverage without passing medical underwriting. (This possibility is supported by the fact that Blue Cross does not have a pre-existing condition limitation for small employer coverage.)

Merging the Direct Pay population with the small employer pool without some sort of open enrollment requirement, waiting period or pre-existing condition exclusion is likely to lead to adverse selection. In the absence of an individual mandate to purchase health insurance and without any additional underwriting restrictions to manage adverse selection, the elimination of the annual open enrollment period could encourage healthy individuals to defer purchasing coverage until they want to use health services. On the other hand, requiring small businesses, even just sole proprietors, to wait for a standard annual open enrollment date might adversely impact the availability of coverage to new small businesses.

On average, the move to small employer would cause rates for current Pool I subscribers, assuming all move to BCBSRI (or at least for those not among the oldest Pool I subscribers since Pool 1 is not age rated), to decrease an average of 4% and rates for Pool II subscribers to increase on average by about 4%. The effect on an individual basis would vary substantially from these averages. The oldest people would

be impacted the most, since rates for Pool II are compressed more tightly by age than small employer rates. It is also important to realize that adding a health status adjustment would impact rates for some individuals as well, with many individuals in Pool I having a health status adjustment of 1.10, and most Pool II people having a health status of less than 1.0. However, Pool II subscribers who have developed health issues subsequent to enrollment could be rated up at renewal under small employer rules, resulting in a factor as high as 1.10 for some Pool II subscribers who currently have the lowest rates.

No commissions are payable on Direct Pay business, since it is only available on a direct basis. This results in a lower expense load for Direct Pay than for small employer business at BCBSRI.

While the impact on overall rates for small employers is not substantial if the Direct Pay population is added to the small employer pool, some Direct Pay subscribers may indeed see large rate increases or decreases as a result. In addition to age and health status differences, the rates would change because of the differences in available benefit plans, and the impact of four-tier demographic type rating. For current Pool II subscribers, the greatest increases would be for females and for people enrolling in full family coverage. Conversely, younger males and people with husband and wife or parent/child only coverage could see the largest decreases. The range of change, not including changes in the value of benefits, might be as great as +/- 40% for those people most affected. (Some of the large increases and decreases might be partially offset by the impact of 4:1 compression.) Increases could be incurred by the healthiest individuals, those who passed medical underwriting, and may result in some younger and healthier members of the Direct Pay population dropping coverage altogether. Conversely, young males might actually see rate decreases.

Direct Pay products were recently revised, and members were required to change benefit plans. Requiring a second change in benefit plan in such a short period of time could create additional confusion for current Direct Pay members. There is the possibility that some will simply drop coverage if another change is imposed on them.

As discussed above, the impacts of merging the Direct Pay pool and the small employer pool are complex, due to the different rating practices for the two populations, the fact that only one carrier currently offers Direct Pay coverage, the differences in the utilization of medical services, the difference in benefit plans, the difference in the use of producers, and the difference in coverage availability (that is, the presence or absence of an open enrollment).

In the absence of research into what actions the healthiest members of the Direct Pay population would take as a result of a merger, we do not suggest merging the Direct Pay and small employer populations at this time. Rather, we believe that further study is needed of

1. the impact of adverse selection,
2. the impact of various underwriting scenarios (including an annual open enrollment for sole proprietors and other “groups of one”) to limit adverse selection,
3. the ability of new small businesses to obtain coverage,
4. analyses of the breakdown of the current Direct Pay population between sole proprietors and others,
5. the differing health insurance needs and desires (if any) between sole proprietors and other current Direct Pay members,
6. the potential differential impact of the merger of the two pools on carriers which currently provide Direct Pay coverage and carriers that do not,
7. carrier reaction to the requirement to accept all individuals into the small employer pool, and
8. the potential impact of such a merger in the absence of an individual health insurance mandate.

3. Maintain the status quo

Today, self-employed individuals have the choice of purchasing either small employer or Direct Pay coverage. Given the discussion in sections 1 and 2 above, we recommend that this choice continue until the results of the study suggested above are available.

It should be noted that BCBSRI favors the elimination of groups of one eligible employee from the definition of small employer, with self-employed individuals eligible solely for Direct Pay coverage. United has not commented on this issue. BCBSRI believes that sole proprietors should not be given more choices than other segments of the population, and that such a change would improve both the small employer and Direct Pay risk pools. However, that improvement would come with a cost to the current small employer groups of one, who would, on average, pay higher costs for lesser coverage if converted to Direct Pay.

While we agree that costs for the small employer pool could be reduced somewhat by eliminating groups of one, we believe the resulting limits on the choice of both product and carrier, as well as the potential for individuals to drop coverage altogether as result of the change, outweighs this benefit.

Although maintaining the status quo with respect to groups of one is not an ideal situation, the Rhode Island market appears to have a relatively reasonable balance at the moment between Direct Pay and small employer coverage.

We suggest that, as a first step toward leveling the playing field for sole proprietors, BCBSRI, together with OHIC, review its Direct Pay rate structure to better align it with the small group rate structure. Of particular interest to consider would be the impact on the Direct Pay pool of changes in the slope of the age factor, the existence of two separate rating pools in the Direct Pay market, other means of age rating, or the availability of four-tier contracts.

This would lessen the disruption in rates should a merger of the two pools (Direct Pay and small employer) be re-considered after the further study outlined above. It might

also decrease somewhat the disparities in rates between the two options (small employer or Direct Pay) for certain individuals.

We also recommend, as stated above, further study of the Direct Pay population to see if there are differences between sole proprietors and non-working individuals in the Direct Pay population and the impact of merging the two pools. Neither eliminating groups of one from small employer coverage nor merging Direct Pay into small employer seems certain to benefit the marketplace as a whole at this time, given current information.

B. Product Portfolio

As mentioned earlier, although they use different definitions of products or benefit plans, both BCBSRI and United have small employer members in approximately fifty different benefit plans. United considers each copayment option a product, and allows multiple prescription drug benefit designs (there are three available) to be combined with each medical plan. BCBSRI matches its drug benefit designs to each medical plan, and permits some co-payment variation within a given product. Thus, in some cases, the differences between the plans are fairly minor—e.g., a small office visit copayment difference—while in other cases the differences are more major—e.g., the presence of a calendar year deductible. This is not unusual in states with guaranteed issue and guaranteed renewable requirements.

Despite the number of products, 75% of members at each carrier are in its five most popular medical plans. (See the section on Benefit Plan or Product Mix for a description of the benefit plans offered by each carrier.)

The multiple benefit design variations and the different approaches to presenting the information make product comparisons both within a carrier as well as across carriers complex and time-consuming. Even producers, who compare benefit plans for a living, mentioned the difficulty of comparing products and benefit plans across carriers.

One reason for this is that the Act requires that carriers include all plans in their proposals and renewals, even those plans which may not be popular. It is our understanding that the main reason for this requirement was to ensure that the statutory plans receive equal play in all marketing literature.

We have three recommendations with regard to product portfolios:

- a) We recommend eliminating the requirement in the Act to sell the two statutory plans, Economy and Standard³¹;
- b) We recommend that, subject to OHIC approval, each carrier be permitted, subject to state and federal requirements for coverage continuation, to discontinue unpopular products and streamline their product portfolios; and
- c) We encourage carriers to educate employers, intermediaries, and producers about the availability of plans with greater cost-sharing options.

1. Eliminate the requirement to sell the two statutory plans

The two statutory plans, as detailed in R.I.G.L. § 27-50-10, provide coverage for up to twenty inpatient hospital days per year and up to 4 office visits per calendar year. Hospital copayments are \$200 per day for the Standard plan, \$300 per day for the Economy plan. Office visit and hospital outpatient coinsurance levels are 20% for the Standard plan and 50% for the Economy plan.

Neither of these plans has sold well, with fewer than 150 subscribers for the two major carriers combined. This is not surprising, as the products provide coverage for neither comprehensive primary care nor catastrophic care. (Also, as stated in Recommendation 8 of the United market conduct examination, contained in Appendix B of this report, we believe that United may not have rated the statutory plans with appropriate benefit

³¹ During the course of the preparation of this report, the Rhode Island General Assembly passed a change to the Act which does just this. The revised Act includes a requirement for a Wellness Plan. The product requirements for this plan were issued to the carriers in mid-December, 2006.

relativity factors.) Given the benefit design, and the lack of popularity of the plans, we recommend that the requirement to offer the two plans be eliminated from the Act.

2. Permit Streamlined Portfolios

Carriers are currently required to describe all their available plans in their proposals and renewals. This is based on the requirement stated in the Act that carriers actively offer all health plans available in their portfolio. It is also important, however, to be certain that a range of plans is offered to all small employer groups. One would not like to see, for example, only benefit plans with very high deductibles offered to the smallest groups, or to groups perceived to be high risk.

In addition, in the past it was difficult for carriers to cancel benefit plans—both Federal law (the Health Insurance Portability and Accountability Act of 1996) and the small employer Act speak to the issue. A change in the Rhode Island small employer statute, effective July 10, 2003, allowed minor plan changes at renewal and made phasing out a benefit plan somewhat easier. Given that, for both carriers, approximately 75% of their members are in the five most popular medical plans, we encourage carriers to consider eliminating long-standing products that have few members and are not very different from more popular designs. While HIPAA requirements about benefit continuation must of course be honored, products with almost no enrollees consume administrative effort, contribute to a more confusing product environment for the consumer, and require additional educational time and energy that could be more effectively spent on benefit plans that are more likely to be purchased.

We are not recommending a specific limit on the number of products a carrier can offer. Nor are we recommending that carriers be limited in the number of benefit options that can be offered. What we are recommending is the ability of a carrier to simplify both its product portfolio, consistent with HIPAA and Rhode Island continuation requirements, and the presentation of this portfolio, to members and potential members, so long as OHIC approves the simplification process. Product simplification will aid consumer and

producer education efforts and improve both member and potential member understanding of coverage options.

We recommend that OHIC approve the plan and process a carrier will use to determine which products or benefit plans to present to each type of employer group, both at initial contact and on renewal, as well as the general wording to be included in the notification. (Please refer to the marketing recommendations for additional comments on this issue.)

Increased ease of product choice, while still providing a portfolio of plans with varying levels of cost-sharing and premium price points, should lead to an improved understanding of coverage options. This in turn may actually increase the number of employers who provide coverage and/or the number of employees who actually enroll when given the opportunity. In addition, product portfolio simplification should decrease internal administrative costs (including the time direct sales staff spend talking with prospective employer groups) as well as the time and effort required by producers to explain options to employers.

3. Encourage Joint Education Efforts

During the course of this study, producers and carriers alike commented on the comprehensiveness of the coverage purchased by most employers, and the slow acceptance of plans with greater cost-sharing. While new groups at both carriers are purchasing plans with greater cost-sharing levels than the most popular plans, the transition for existing groups to plans with greater cost sharing appears very slow. We were particularly struck by the low level of emergency room copayments found in the most popular small employer plans. Such co-payment levels are a relatively simple way to discourage inappropriate use of an emergency room. Higher emergency room copayments result in premium savings much greater than the simple differential in copayment levels might suggest, as emergency room visits typically result in multiple tests and/or procedures which increase the overall cost of care.

While each carrier offers a range of benefit options, the range of benefit relativities on the top five plans is fairly compact, although the spread is greater for United than for

BCBSRI. If we assign to the most comprehensive product for each carrier a relative value of 1.0, the actuarial values of the plans which enroll approximately 75% of each carrier's small employer membership range from approximately 0.89 to 1.00 for Blue Cross and from approximately 0.75 to 1.00 for United. For all members and all products combined, the overall average benefit value for Blue Cross is 0.94 and for United it is 0.85.

The intuitive sense of the producers we spoke with and the small employer carriers is correct—the benefit values of small employer plans in Rhode Island are fairly high, and within a tight range, particularly at Blue Cross.

Effective October, 2005, carriers were permitted to sell Consumer Directed Health Plans in Rhode Island. These products have a high, up-front deductible but coverage is typically 100% after that deductible is reached. These plans work in conjunction with a Health Savings Account (HSA), a tax-advantaged vehicle which enables employers and/or members to set aside funds to be used to pay for health care services which go toward the deductible. The theory behind these plans is that consumers will be more cost-conscious when using health care services because they have control over the spending in the Health Savings Account. To the extent that they choose the most cost-effective sites and/or services for care, the dollars in the HSAs will go farther. In addition, funds unspent during a plan year can be carried over to future years. Both carriers have consumer-directed plans with a range of deductible values. At both carriers such plans have benefit values at or below 60% of the most comprehensive plans.

Producers commented during the survey on how difficult it is to explain the various plan options to employers. Some producers mentioned that many of their peers do not understand all the plans, particularly the new consumer-directed health plans. Often the choice between an employer offering insurance or not can be resolved by the ability to offer a product with greater cost-sharing levels. We therefore encourage carriers and OHIC to assist producers, employers, and members in understanding the trade-offs involved in choosing a health insurance product with more cost-sharing than they are

currently purchasing. The more the public understands about all available products, the more intelligent the product selection decisions will be.

C. Distribution System

Both major carriers make significant use of an external distribution system. Both carriers market their products through producers. Additionally, BCBSRI uses a general agent to develop and manage its producer network and uses intermediaries as an additional marketing channel. Producers and intermediaries will be collectively referred to as “producers.” Producers play an important role in educating employers and helping them to choose the health plan that is best for them. Carriers would need additional direct sales and support staff if the level of producer and intermediary business were reduced.

Producers are paid a commission for their work effort. For both BCBSRI and United the commission is subscriber based—that is, producers are paid a fixed amount for each month that a subscriber’s premium is paid. In addition, both major carriers pay a bonus to producers based on criteria that vary for each carrier, but that may include total book of business, new business written, lapse rate, and other coverages sold. (The bonus programs are discussed in more detail in each of the two carrier-specific reports. They are also mentioned in the Distribution Systems and Costs section of Components of a Health Insurance Rate.)

Additionally, BCBSRI’s health plans are endorsed by the Rhode Island Builders Association and various Chambers of Commerce. BCBSRI provides compensation to these entities for the marketing and administrative services that they perform.

In a time of rising medical costs, it is important for employers to understand fully the non-health-care expenses which are built into health insurance premiums. This is why we recommend in Carrier Reporting to OHIC that data concerning administrative expense and investment income credit be collected annually by the OHIC. It is also why we have taken a look at one readily-identifiable component of administrative expenses, external distribution costs. For the one carrier for which we could compare administrative expense levels for small employer business with administrative expense

levels for large groups, over 80% of the difference in administrative expense load was due to external distribution costs. (It is more expensive, on a per member per month basis, to sell and maintain a small employer group than a large employer group; however, this carrier did mention that internal sales are less expensive than external ones.)

1. Payment of Commissions

A producer's presumed role is to represent the employer. The employer looks to the producer to recommend the carrier and health plan that best meets the needs of the small employer. One of the main purposes of the commission is to compensate the producer for his/her work effort in (a) explaining available health insurance products, (b) determining the carrier and benefit plan which best meets each specific employer's needs, and (c) assisting the employer and employees with the paperwork involved in enrolling an employer's employees and dependents.

Payment for this work effort—the commission—is built into small employer premium rates. The carriers pay the producers, intermediaries, and the general agent for their services. Since small employer rates may vary only based on age, gender, health status or family composition type, all small employers contribute toward the cost of the external distribution system, whether they use a component of the external distribution system or not. The level of compensation to the external distribution system built into small employer rates in 2005 was approximately 6%³² of premium for United and approximately 3% for BCBSRI. These percentages are based on commission payments of \$21 per contract per month at United and \$18 per contract per month at BCBSRI to producers and bonus payments. The cited percentages also include payments to intermediaries, the general agent utilized by BCBSRI and payments to entities that endorse a carrier's health plan. BCBSRI pays Intermediaries \$21 per contract per month and its general agent \$8 per contract per month for all its producer business. The

³² United included some Massachusetts data in its commission database. Therefore, this number may be overstated for Rhode Island alone.

general agent is involved in all producer business at Blue Cross, so the total compensation that Blue Cross pays for producer business, not including any earned bonus, is \$26 per contract per month.

Both carriers recently switched from compensating producers on a percent of premium commission scale to the flat dollar amounts cited above. We believe this change was appropriate. A percentage-based commission, which of course pays a producer more for a higher-priced product than a lower-priced product, has the potential to influence producers to recommend higher-priced products. A flat monthly payment also eliminates increases in commissions due to medical inflation.

Of course, direct sales do not come without cost. Internal sales staffs require salaries, fringe benefits, and general administrative expenses. The cost of internal sales staff are also distributed across all subscribers. Internal sales and marketing staff also provide assistance to producers, intermediaries, and general agents.

We are concerned about the level of distribution costs in the small employer market in Rhode Island, particularly because there are only two major carriers. These costs are not readily apparent to employers because they are built into premium rates. Given the high cost of health insurance, and the trend toward transparency in many other aspects of the cost of health care, we believe that it would be helpful for all purchasers of health insurance to understand the costs involved in the external distribution system. These costs need to be understood both by those using the services of a producer as well as those who do not use the services of a producer but still pay for such services.

The DBR recently issued Insurance Bulletin Number 2006-2, Producer Compensation Disclosure. This Bulletin, among other items, requires producers to inform their clients if they receive a commission or a contingent commission from an insurance carrier. Informing clients of that employer's specific level of commission is not part of the requirement. Also not part of the requirement is for a carrier to inform employers which do not use producers that their rates include a proportionate share of the cost of the external distribution system. (Should this knowledge encourage some employers to take

advantage of a producer's services, which would be the case if they were refraining from doing so because they thought there was a fee, the greater the level of commissions which would need to be built into the rates, potentially partially offset by changes in internal marketing costs.)

In order to increase transparency, we recommend the following, phased approach to enable all parties involved in the small employer market to gain a greater understanding of external distribution costs:

1. We recommend that OHIC require carriers to work with only those producers who disclose to their clients the monthly and projected annual commission he/she will receive as a result of placing the client's business.
2. We recommend that all carriers be required to file their small employer commission schedules with OHIC. It is our understanding that BCBSRI is required to do this as a result of its enabling legislation, but that other carriers are not currently under this obligation.
3. We recommend that each carrier be required to itemize the external distribution costs in its proposals and renewals to all employers so that they are made aware of what is included in the rates for the external distribution channel.

As a longer term solution, we recommend that OHIC work with the producer community to discuss the following possibilities:

- making the external marketing costs a rating variable that is not subject to compression; or
- having producers bill clients directly for their services.

Both of these suggestions result in having only those employers which use producers paying for those services.

2. Volume or persistency-based bonuses

Each major carrier in Rhode Island has a bonus program that provides additional compensation to its producers over and above the per contract per month commission payments. As discussed earlier, United's bonus payments were an additional 20.1% of commissions, while at Blue Cross bonus payments were an additional 3.4% of commission payments.

As a further step toward eliminating any financial motive on the part of a producer to recommend a specific carrier and/or benefit plan to an employer, we recommend that volume and/or persistency-based bonuses be prohibited in the small employer market. These bonuses are paid when a producer reaches a certain total level of business with a carrier (volume) or when a producer's clients remain for a specified length of time with a carrier (persistency). Carriers like these bonuses because they encourage loyalty and reward their major and repeat producers, not unlike the awarding of frequent flier miles by major airlines.

We do not argue with the carrier's perception that producers add value to the purchasing decisions for small employer health coverage. In fact, research bears this out.³³

However, compensation based on the total number of contracts a producer places and/or renews with a particular carrier is considered contingent compensation. Contingent compensation creates the potential of providing the producer with a financial incentive that might conflict with his/her duty to best represent the small employer. For example, if ten additional contracts will put the producer into a new bonus category at a particular carrier, the producer may then have a financial incentive unknown to the employer to recommend that particular carrier.

³³ Conwell, Leslie Jackson; Center for Studying Health System Change, "The Role of Health Insurance Brokers, Providing Small Employers with a Helping Hand," Issue Brief No. 57, October, 2002.

Compensation systems which encourage a producer to steer a client toward a particular carrier, whether or not that particular carrier best meets the needs of the employer, are not in the best interest of the employer.

Volume and persistency-driven bonuses have come under much disfavor in the life and casualty insurance markets. While we do not have evidence suggesting that producers in Rhode Island are adversely influenced by contingent compensation, we believe that prohibiting volume and persistency-driven bonuses will avoid any potential problems in the future.

3. Marketing

We recommend expanding the definition of “actively market” to require carriers to assist OHIC with community education efforts, including the development and maintenance of the components of the educational website and brochures that we recommend OHIC develop (see OHIC Education Efforts). As mentioned earlier, lack of knowledge about the availability of coverage, carrier and product choices, and where one goes to obtain coverage is perceived as a major problem in Rhode Island. One carrier has expressed an interest in enabling a link from the OHIC site to their own; we believe this would be helpful.

We also believe that it would be beneficial to provide carriers more leeway, as stated earlier, in presenting products and benefit plans to both prospects and renewing groups. Presenting an array of twenty to fifty products, with accompanying rates, is simply more information than most employers have the time to adequately compare, even with the help of a producer. Together with product portfolio simplification and the elimination of the requirement to sell the statutory plans, we believe that carriers should be given more discretion with respect to marketing all products equally.

One important caveat—as stated previously, we recommend that OHIC be involved in the development of, and ultimately approve, the process for determining which benefit plans will be offered to what types of employer groups, both initially and on renewal. We also recommend that OHIC approve the wording of any notifications about the

discontinuance of benefit plans. The participation of OHIC should avoid any potentially inadvertent adverse selection resulting from the change from marketing all benefit plans equally.

For marketing materials geared to new business, we recommend carriers be permitted to emphasize specific products while still presenting a range of benefit options with varying levels of cost sharing. We recommend that carriers also continue to make all products known and available to all groups. For renewal business, we recommend that carriers be permitted to present rates for products that they believe, based on the carriers and/or producers experience, the employer would be interested in. This recommendation comes with two important caveats: (a) a renewal rate for the employer's existing product must be presented; and (b) employers must be informed that other products are available, and that rates will be provided on request.

And, while not recommended as a regulatory requirement, we encourage both carriers to explore more pro-active direct sales techniques, such as telemarketing or the ability to provide a quote directly to employers through the carrier's website. These can be cost-effective means of attracting and enrolling new small employer groups.

D. Rating Requirements

Both major carriers are interested in seeing changes to the allowed rating variables. In general, the changes desired by carriers serve to lessen cross-subsidies within the small employer pool and to charge more to those expected to use more medical services, while charging less to those expected to use fewer services. While this may be viewed by some as increased "accuracy" in rates, it is also contrary to one of the purposes of the Act—spreading health insurance risk more broadly.

Community rating favors more cross-subsidies within an insurance pool, not less. The goal of pure community rating is to spread the costs of all expected services over all members, so that the sick and healthy share equally in the cost of care.

The Rhode Island small employer statute, as originally drafted, mandated adjusted community rating, with age, gender, and health status as rating variables with 4:1 compression as a restraint on the overall variability of rates. The original statute envisioned a migration toward full community rating, with the elimination of health status as a rating variable and the transition from 4:1 compression to 2:1 compression at future dates. While not leading to full community rating (adding together all expected claims and administrative expenses and dividing by the total number of contracts, not making any adjustments for age, gender, health status, etc.), the original statute moved closer toward that end over time. The original statute has been amended, to maintain 4:1 compression and to continue to allow health status as a rating variable.

Consideration can be given as to whether to re-start the migration toward full community rating, to remain part way there (i.e., the status quo), or to move further away from it. A move further away from community rating would allow carriers greater flexibility to adjust the average community rate based on variables which are expected to have an impact on a particular group's cost of care and thus the particular group's expected claims experience or administrative costs. We will discuss each rating factor in turn.

1. Rating by Industry or Size of Group

Currently, the only variables carriers are permitted to use for rating purposes within the small employer risk pool are age, gender, family composition, and health status. (We will discuss health status and the 4:1 compression band in the following sections.)

Neither carrier specifically expressed an interest in changing the requirements of age or gender rating. Carriers have, however, expressed an interest in adding size of group and industry to this list. Adding either of these elements to the list of permitted rating variables would further fragment the small employer risk pool, moving further away from community rating.

We do not support either of these suggested additions. Please refer to the section titled Managing Groups by Size, Particularly Groups of One Subscriber, for a discussion of segmenting the risk pool by size.

Industry rating may fragment the total small employer pool to such an extent that the resulting pools are too small to be credible. Historically, industry rating has been implemented with substantial variability by carriers. Generally individual carriers do not have sufficient claim experience to establish industry ratings, except at a very high level. Thus, industry ratings could reflect subjective judgments rather than underlying claim experience and could result in a form of redlining of certain industries. It is our conclusion that segmentation by industry would harm the small employer market in the aggregate.

Industry rating does nothing to impact the overall cost of health insurance, unless it discourages employers in certain industries from seeking or purchasing coverage, a result totally contrary to the purposes of the Act. To the extent that small employer groups do not leave the market, industry rating results in the redistribution of costs among different employer groups. And, even if one accepts the premise that the industry an employer is in is a solid predictor of health care costs, industry rating works contrary to the goal of preventing “segmentation of the health insurance market based upon health risk.”

Industry rating may result in increased rates for certain small employers in industries that are considered higher risk, thus perhaps making it less likely that they would purchase or maintain health insurance. The actual impact of industry rating would depend upon whether or not it is subject to any limitation, similar to the limitation that exists currently for health status adjustment.

While the impact of using group size or industry as a rating variable would also be moderated somewhat because of compression (assuming it would be impacted by the compression adjustment), we do not recommend allowing carriers to add size or industry to the list of factors permitted to impact the rates within the compression band.

2. Health Status Adjustment

Currently, carriers are permitted to adjust rates for health status within a +/- 10% band of the adjusted community rate. That is, the adjusted community rate can be decreased

by up to 10% for groups that are expected to experience less than average claims and increased by up to 10% for groups that are expected to experience more than the average level of claims. Moving to full community rating would mean eliminating the ability to adjust rates for a group's health status. Blue Cross favors expanding the ability of carriers to adjust rates for health status from +/-10% to +/-25%.

Some rate differentiation between the healthy and the ill could help attract and retain in the risk pool younger and healthier individuals. In a system of full community rating, there would not be any rate differential between the young and healthy and the oldest and sickest individuals.

The process a carrier uses to determine an appropriate health status adjustment factor may be costly and labor intensive when based on an analysis of member health conditions, but it does result in an adjustment to a group's rate based on expected claims usage.

Health status factors do not seem to add significantly to rate volatility in the Rhode Island small employer market. At one major carrier, for 44% of the groups the health status adjustments stayed the same from year to year, with 20% of the groups experiencing a decrease and 36% experiencing an increase. At the other major carrier, for 60% of the groups, the health status factor stayed the same from year to year, with 20% experiencing a decrease and 20% experiencing an increase. If the health status adjustment were prohibited, 75% of groups at BCBSRI would be impacted by 4-10% change in rate, up or down. This is because they currently have a health status factor other than 1. At United, assuming re-centering of rates to reflect the loss of the health status adjustment, about 75% of groups would see a rate increase of 2 to 3%, while the remainder would see decreases ranging from 2 to 18%. (One reason this number is so high is that it includes the effect of correcting a compliance problem with the application of the health status adjustment.)

While we support some level of health status adjustment, we believe that a 50% spread—25% below to 25% above the base rate, as recommended by BCBSRI—would

lead to major variations in rates between the healthiest and sickest groups. This would significantly decrease the subsidy of the sicker groups by the healthier groups and potentially lead to rates for unhealthy individuals which are no longer affordable. This would be contrary to the goal to “spread health insurance risk more broadly.” We therefore recommend maintaining the health status adjustment spread at 10% up or down.

We also recommend eliminating the provision in the statute which limits the ability to rate by health status to carriers that used such adjustments as of June 1, 2000 (R.I.G.L. § 27-50-5 (a) (2)). While this section of the law was needed when the health status adjustment was scheduled to be eliminated, it currently only serves as a barrier to a carrier that wants to enter the small employer market in Rhode Island. If a new carrier entrant in the small employer market is prohibited from using health status and the current carriers use a health status adjustment, it stands to reason that the healthier groups will gravitate to carriers that will give them a discount while the sicker groups will gravitate to carriers that do not provide a surcharge. Such selection in the marketplace will eventually lead to prohibitively expensive rates for carriers which are not permitted to use a health status adjustment. Since all potential new entrants to the Rhode Island small employer market will be aware of the disparity in permissible rating factors, maintaining the prohibition on health status adjustments for carriers not using such factors prior to 2000 is a major deterrent to new entrants, and should be eliminated.

3. 4:1 Compression

4:1 Compression refers to the requirement in the statute that, for each carrier, the rates which result from the combination of all rating variables (age, gender, and health status) for each family composition type, benefit plan and effective date must be limited so that the highest rate for any group cannot be more than four times the lowest rate for any other group. The requirement of 4:1 compression results in an additional protection for the older and less healthy groups and results in a subsidy of these groups by the younger and healthier groups.

**The Effectiveness of the Small Employer Health Insurance Availability Act in Promoting Rate Stability,
Product Availability, and Coverage Affordability**

Full community rating would have a 1:1 compression—all groups would pay the same amount regardless of age, gender, or health status. Originally, compression was scheduled to collapse to 2:1 effective July 13, 2002. This was changed twice—once, to delay implementation of 2:1 compression until October 1, 2004 and then again to maintain the 4:1 compression on a permanent basis. Carriers, and some producers we spoke with, proposed having compression expanded to 6:1 or 8:1. A broad compression band would enable carriers to link each employer group’s rates more closely to its expected claims experience, moving further away from community rating.

Data to calculate the potential impact of changing the compression ratio are available for only the BCBSRI population, which represents 80% of the total small employer business in Rhode Island. The table below depicts the percent of groups and subscribers impacted by both the minimum and maximum values of compression at four different levels of compression, assuming the band is moved an equal distance from the current top and current bottom. This represents the difference in rates as compared to an environment in which the current rating factors were maintained, but no rate compression was required.

Impact of Compression	Current 4:1 Compression	1:1 No Compression	2:1 Compression	6:1 Compression
% of Groups Seeing a Rate Increase	3.1%	54%	11.5%	1.5%
% of Subscribers Seeing a Rate Increase	1.4%	53%	6.5%	0.6%
Average Size of Increase for those with an Increase	15%	26%	31%	8%
Percent of Groups Seeing a Rate Decrease	7.2%	46%	14.7%	2.1%
Percent of Subscribers Seeing a Rate Decrease	3.0%	47%	8.3%	0.8%
Average Size of Decrease for those with a Decrease	16%	24%	22%	9%

Of course, the broader the compression band, the fewer groups and subscribers are impacted by either an increase or a decrease due solely to compression. For example, currently 7.2% of groups (those with the highest calculated rates) experience a decrease because of the application of 4:1 compression while 3.1% of groups (those with the lowest originally calculated rates) experience an increase due to the application of 4:1 compression.

The impact of broadening the compression band is a decrease in the subsidy provided to groups with older and/or sicker members. If there were a move to 6:1 from 4:1, the rates of some of the older and sicker groups would no longer be decreased or they would experience a lesser decrease. At some point, the rates for these groups might become so high that employers would have to drop coverage.

With a broader band for compression, carriers would have more room to fully reflect in their rates the impact of the allowed rating variables (e.g., age, gender and health status) that make up the variability within the band.

It should be noted that carriers have flexibility in how they implement the compression requirement. One cannot assume (as we have for this analysis) that the band would widen equally from where it is now. It is possible that carriers could put more of the additional ability to change rates at the top end of the band, thereby raising rates for the oldest and sickest even more than we have assumed while not lowering rates for the younger and healthier groups as much as we have assumed. It is also possible that a carrier could change how it applies the current 4:1 compression to its book of business.

We do not support widening the range within which rates can vary because a wider compression band might make coverage prohibitively expensive for some groups, and thus lead to an increase in the number of uninsured. A wider compression band would be contrary to the Act's goal of spreading health insurance risk more broadly.

At the same time, however, we do not recommend reinstating the originally planned implementation of a 2:1 band, or moving to full community rating, a 1:1 band. At 2:1 compression, the average increase due to compression would be 31%, in contrast to an

average 15% average increase under 4:1 compression for a smaller number of groups. Such changes may not be affordable for many groups and they might drop coverage altogether. Given that these groups represent 6.5% of subscribers under the 2:1 scenario, the groups impacted would on average be the smaller groups. A move to 1:1 compression would increase premium rates for roughly half of the employer groups.

4. List billing

Currently, employers are provided one rate for each family composition type—individual, employee plus child(ren), employee plus spouse, or family (employee, spouse, and child(ren)). Carriers combine the age, gender, and health status information for each member of the group and reflect the result in the four family composition rates for the group. Thus, an employer is charged the same rate for each subscriber in a particular family composition type—the charge for a thirty year old individual subscriber is the same as the charge for a sixty year old individual subscriber.

One carrier has suggested that this approach be changed for groups of fewer than ten subscribers, and that “list billing” be permitted for these groups. Under list billing, the employer would be charged a premium for each employee that reflects that employee’s demographic characteristics—the employer would be charged less for a thirty year old than for a sixty year old. Each month, the employer would be presented with a bill which lists each subscriber and the specific rate associated with that person and his/her dependents based on the family’s demographics (with the exception of health status, which is applied to the group as a whole).

One reason for the carrier’s recommendation to allow list billing is the opinion on the part of the carrier that small employers can and do “game” the system. There is a suspicion that some small employers postpone hiring older and/or sicker individuals until after an annual renewal, or add younger and/or healthier people just prior to a renewal, and then let those people go. We note, however, that no evidence of this practice was provided or detected in the course of the market conduct examinations.

We believe there are other more appropriate options under the existing law for dealing with employers who are not truthful on their annual re-certifications. Rather than “gaming” the system, we would call this type of behavior by a small employer “fraud.” In addition, rates can be changed in the midst of a contract year due to “changes to the enrollment of the small employer.” (R.I.G.L. § 27-50-5(b)(1)). We encourage OHIC to interpret this to include a significant change in the age/gender composition of the group, not just one particular contract changing from individual to family.

The carrier advocating list billing stated another perceived benefit—it avoids a major change in the renewal rate if there has been a significant change in the demographics of the employer’s population during the course of the year. An employer that grows from a group of two young individuals to a group of ten with many older employees may see a large rate impact from one renewal to the next. We believe, however, that this change is readily understood by small employers if the carrier and/or producer take the time to explain the reasons to the employer.

There is another, more important reason that we do not support list billing. List billing highlights for employers the rate impact of hiring (or maintaining on the payroll) an older employee, or an employee with an older dependent. It also could expose the older employees to paying more of the cost of their health insurance themselves, and potentially result in some of them dropping coverage.

E. Additional Protections for More Even Risk Distribution

1. Reinsurance or Risk-Adjustment:

In the absence of dramatic changes in utilization or cost patterns, one way to moderate the overall rates charged to small employer groups is to implement a reinsurance program or a high risk pool funded from outside the health insurance system.

Reinsurance involves capping a carrier’s liability for a particular member at a set amount (e.g., \$75,000) and providing coverage for a major percentage of claims above this amount (e.g., 80%) from a central source. It would be inappropriate to cede 100% of claims above the selected amount to the central source because that would eliminate

any financial incentive on the part of the carrier to manage care for people with such large claims.

A high-risk pool works in a similar fashion, except that individuals with high cost claims are typically removed from the carrier's risk pool altogether and covered by a central source. Funding of the cost of these claims is currently borne by the carriers; with a high risk pool the funding could come from the carriers, from a source external to the health insurance market, or from a combination of these. Depending on how the high risk pool is organized, individuals whose claims are ceded to this pool may or may not be aware of the practice.

Prior to reviewing the distribution of high cost claims across carriers we were prepared to recommend that OHIC study a reinsurance program. When funded with dollars from outside the health insurance system, reinsurance removes the major portion of high-cost claims from health insurance premiums and could provide a subsidy to small employer rates. Rates are then calculated without such high claims, resulting in lower rates for all. We estimate that a reinsurance program that ceded 80%³⁴ of claims in excess of \$60,000 and funded by dollars outside the health insurance system could result in removing approximately \$12 million to \$16 million dollars from expected claims costs in the small employer pool in 2007, assuming that the full cost of reinsurance is funded from an external source.

However, our review of data from the two major small employer carriers leads us to a different recommendation. The distribution of high cost cases across the two major carriers can be found in the Claims Expense section of this report. BCBSRI apparently had a higher percentage of its members incurring large claims than did United in 2004. Based on the sample provided, only 1% of United's members who had incurred claims had claims in excess of \$20,000 in 2004, while 1.7% of BCBSRI total members had claims of this size. (The BCBSRI percent would be even higher if it were based only on those members who incurred claims, as is the United figure.) As for claims in excess of

³⁴ Ceding 80% of claims rather than 100% provides the carriers with a continuing incentive to manage care.

\$20,000, again, based on the sample, 25% of United's claim dollars were in this category. At BCBSRI, 30% of claim dollars were for claims above \$20,000. All else being equal, including both care management capabilities as well as no selection between the two carriers, one would expect high cost cases to be distributed proportionally across the two carriers.

We therefore recommend that OHIC monitor this issue closely and require that annual reports from carriers include information about the distribution of claims. Should the disparity in high cost claims continue, we strongly recommend that OHIC either pursue the development of a high risk pool (funded either by premiums imposed on carriers or an external source) or use its existing authority to implement risk adjusters to distribute the cost of large claims across carriers. OHIC is authorized to develop and implement a system of risk adjusters by R.I.G.L. § 27-50-16. Should the distribution of high cost claims across carriers even out, we would then recommend a reinsurance mechanism, with funding from outside the health insurance system.

2. Administrative Services Only (ASO) Plans

Rhode Island is now experiencing the marketing of administrative services only agreements to small employers. Such arrangements are generally marketed in conjunction with an insurance contract (stop loss) that limits the employer's liability for claims. Under such an arrangement the employer pays an administrative fee to the carrier plus the cost of the actual claims incurred by the employees enrolled in the health plan. If the level of claims exceeds specified limits, the stop loss contract reimburses the employer for such claims. Such ASO arrangements and the accompanying stop loss policy are not subject to the Act.

Larger groups frequently purchase coverage on an ASO basis because they have many members across which to spread claims. Even so, they typically purchase individual and aggregate stop loss coverage to protect them against particularly large overall adverse claim experience. For a small employer, however, even one unexpected

\$50,000 claim could be devastating. This is why ASO business is more typically found among very large employers.

An ASO arrangement might be most attractive to the youngest and healthiest small employer, typically those groups that may be subject to an increase due to the application of 4:1 compression. The effect of such groups leaving the small employer pool could result in increased rates for the remaining small employers. The presence of ASO arrangements in the Rhode Island market allows small employers to select against the small employer risk pool, to the detriment of other small employers.

In order to discourage small employer ASO business in the future, we recommend that Rhode Island consider the enactment of legislation that prohibits Third Party Administrators and/or insurers from providing administrative services and stop loss insurance to employers who qualify as small employers under the Act.

Other states have legislation which accomplishes this. New York State prohibits reinsurance and/or administrative services only contracts for small employers. Legislation was previously introduced in the Rhode Island General Assembly to protect small employers by requiring specific attachment points.

Placing limits on the attachment points that can be sold to small employers does not eliminate the selection issues with respect to eliminating healthier people from the pool. Therefore, we believe it is important to prohibit ASO arrangements within the small employer market.

3. Rate Review

Chapter 27-50 does not include a requirement for carriers to file small employer rates with OHIC. It is our understanding that the requirement for periodic market conduct examinations was intended to be the means by which OHIC monitored carrier compliance with the rating requirements of the Act. However, the unresponsiveness of one major carrier, United, to provide sufficient data to enable a complete and comprehensive determination of compliance with the rating provisions of Chapter 27-50

raises the issue of whether or not a rate review process for small employer rates is necessary.

We recommend that OHIC, after further review of United's inability to provide data, assess the need for a small employer rate review process.

4. Minimum Loss Ratio Requirement

While not an issue of concern with either of the two carriers that have been examined to date, we believe that a minimum loss ratio requirement will provide additional protection to consumers in the Rhode Island small employer market. We recommend that OHIC consider proposing to the appropriate parties the inclusion in the Act of a minimum loss ratio requirement no lower than that included in the National Association of Insurance Commissioners' model legislation.

5. Minimum Participation Requirements³⁵

"Participation" refers to the number of eligible employees and dependents who enroll in the small employer health plan offered by their employer. Eligible employees and dependents who do not enroll because they obtain health insurance coverage elsewhere (usually through a spouse) are considered to have "waived" coverage. Eligible employees and dependents who do not have creditable health insurance coverage and who do not enroll in their employer's health plan are considered to have "declined" coverage.

The Act does not currently permit carriers to have a minimum participation level greater than 75% of eligible employees who do not have other coverage. This provision applies equally for all small employers.

Carriers typically prefer high rates of participation, as this decreases the potential for adverse selection. Individuals who "waive" coverage are neutral in this regard, but

³⁵ During the course of the preparation of this report, the Rhode Island General Assembly passed a change to the Act which resolves this issue as recommended here.

individuals who “decline” coverage might be assumed to be healthier than average because they are willing to forego possible enrollment until the next open enrollment or a special event as defined in the Act.

Allowing carriers to raise the minimum participation level to 100% for groups of 10 or fewer eligible employees would decrease the number of groups eligible for coverage, and thus increase the number of uninsured individuals in Rhode Island.

Although the Act does not allow a carrier to impose a more stringent participation requirement than was in effect at the time a specific group was initially underwritten, we can analyze the effect of implementation by both carriers of a 100% participation requirement. If such a requirement had been in effect when the carriers’ current business was underwritten, approximately 300 groups with a total of 2000 subscribers would not have been written. The negative impact would be felt primarily by groups of size 6-10.

We recommend enactment of legislation that maintains the minimum participation level at 75% for all size groups.³⁶

6. Health Status—Data Collection Tool

Both major carriers require that each employee in groups of fewer than twenty enrolling employees provide information about their and their covered dependents’ medical history at the time of enrollment in the health plan. The carriers use different forms. United uses one form for groups of 1-9 enrolled subscribers and a different form for groups of 10-19 enrolled subscribers. United’s form for groups with 1-9 enrolled employees is substantially more detailed than that used for groups with 10-19 enrolled employees. BCBSRI, on the other hand, uses the same form for groups of 1 to 19 enrolling employees.

³⁶ The Act was recently amended to accomplish this.

Both carriers ask the employer to provide medical history information for the larger groups, those with 20 or more subscribers. In certain cases, follow-up telephone calls may be made if the information provided by the employer warrants collecting additional medical data from a particular employee. In addition, Blue Cross has extensive historical claims experience that it can, and does, review.

Medical history collection techniques can act like a form of “back door” underwriting—a means of discouraging sicker individuals from applying for coverage. This is particularly true in the smallest groups, where employers are more familiar with their employees and more likely to know the employee’s and/or a dependent’s health information. When an employer sees that one carrier is asking employees a list of fifteen health-related questions while the other is asking seven, the employer with sicker employees may be tempted to choose the carrier that asks fewer questions. In addition, at the individual employee level (and also for groups of one), the more questions one has to answer, the more likely one might be to forego applying for coverage if one has to respond “yes” to multiple questions. (There may be some mitigating effects to this since the more times one has to answer “yes,” the more one may appreciate the need for health insurance.)

Collecting medical information at the time of enrollment is essential for the development of the health status factor. We recommend, therefore, that OHIC require that all carriers use a standard medical history collection form at the time of initial enrollment. (Neither carrier requires this information from enrollees at renewal, since they evaluate health status at renewal based on claims experience.) This would minimize any potential carrier selection due to differential risk assessment questionnaires. We recommend that OHIC develop this tool in conjunction with the carriers, so that to the extent possible the carriers’ data needs are met.

7. Certification of Employee Eligibility

Carriers are currently required to re-certify the eligibility of each group, and eligibility of each employee within the group, at every renewal. This requires a significant ongoing administrative effort for both major carriers. Historically, however, when eligibility

determinations were lax, the smallest small employers have been assumed to provide coverage for individuals who may not have been eligible based on underwriting rules. In order for the carriers to protect the integrity of their small employer pools, and in order for OHIC to ensure that the small employer pool of each carrier is not supporting ineligible claims risks, it has been important to both the carriers and OHIC to ensure that only eligible employees are covered.

The carriers now believe that the efforts over the last few years have removed from coverage individuals and groups who are not eligible for small employer coverage. We therefore recommend that employer and employee eligibility certification be required when a group first enrolls, and that eligibility be verified for any new employee and/or dependent who requests to enroll in the health plan. Subsequent complete re-certification of all eligible employees, or re-certification of a particular employee and/or dependent, should occur at the discretion of the carrier.

We also recommend a standardized form be used by all small employer carriers for collecting certification information. This would prevent any risk selection between carriers due to differences in the carrier's documentation requirements. Again, we suggest that OHIC work with the carriers to develop an acceptable form which meets the carriers' data collection needs.

8. Carrier Reporting to OHIC

Carriers currently provide information about their small employer business to OHIC on an annual basis. In order to provide OHIC with more detailed information to assist it in analyzing year to year changes in the marketplace and as a result make ongoing policy adjustments as needed, we suggest that the following data be required from each carrier:

- Membership by group size (number of groups, number of subscribers, and number of members)
- Membership by age

The Effectiveness of the Small Employer Health Insurance Availability Act in Promoting Rate Stability, Product Availability, and Coverage Affordability

- Premium and claims for the five most popular benefit plans
- Premium and claims by group size
- Enrollment (both number of groups and number of subscribers) by plan, and associated plan relativity factors
- Descriptions of care management programs in place, and the results of those programs in the Rhode Island small employer market
- Distribution of claims costs by percent of members with claims and by size of claims
- Average rate increases
- Average loss ratios by group size
- Administrative expense rate
- Investment income credit
- Average per member per month medical costs

In order for these reports to be meaningful, the information must be comparable across carriers. We therefore recommend that OHIC work with the carriers to develop consistent definitions and time periods for each data element. This will ensure consistency across carriers. For example, categories of group size need to be decided jointly. In addition, since the carriers have different data systems, certain items may not be readily available from each. Discussion among all parties is needed prior to finalizing the required components of the report so that, if necessary, carriers are given time to provide data that is deemed essential by OHIC but is not currently, readily available.

9. OHIC Education Efforts

i. Website

It is evident from speaking to carriers, producers, and OHIC staff that the lack of knowledge about the availability of coverage, carrier and benefit plan choices, and where one goes to obtain small employer coverage is a major problem in Rhode Island.

As carriers introduce new plans, and plans become more complex (e.g., consumer-directed health plans and associated health savings accounts) this situation will only worsen.

We therefore recommend that OHIC establish and maintain a comprehensive, educational website. We suggest that the website include, in easy to understand terms, information about:

- Who is eligible for small employer coverage
- Carriers in the market
- Descriptions of product types (e.g., HMOs, PPOs, POS products)
- Descriptions of what to look for in a benefit plan
- Guidance on how to choose a plan that's right for an employer
- Description of how small employer rates are calculated
- Where does a sole proprietor find coverage
- The availability of wellness programs at each carrier
- Places to turn for help, including producers

The publication of hard copy brochures on each of these subjects will also help to disseminate information among the employer community. In addition, OHIC can produce short podcasts featuring small employer group health insurance updates. For more comprehensive information-sharing, we suggest producing webcasts on key issues, including Q&A sessions that will keep the information relevant and foster dialogue. Additionally, consumer-friendly collaterals that tie into web-based programming will increase reach and retention. These strategies have proved successful in other states.

We believe that OHIC, with help from the carriers, needs to play a major role in ensuring that easy access to objective, comparable information is provided to the community as a

whole. Funds from general revenues and/or a carrier assessment could be used to fund the development and maintenance of this website.

ii. Speakers Bureau and Community Education Efforts

We also recommend a full-scale community education effort in conjunction with this website. We believe it would be helpful for OHIC to train individuals (interested community residents, retired workers from the health insurance industry, retired small business owners, etc.) to meet with employer groups to discuss the requirements of small employer eligibility and rating as well as available products. These individuals, overseen by OHIC, would comprise the OHIC Speakers' Bureau.

A speakers' bureau would make individuals available to meet with gatherings of small business owners, producers, and any other parties interested in small employer health coverage. The brochures mentioned above can be distributed at such speaking engagements. The more the population understands the rules and requirements of small employer health insurance and the available benefit plans, the better purchasers of coverage they will be.

10. Notification to OHIC on Market Entrance

The Act applies to all small employer carriers doing business in Rhode Island. However, until such time as the required annual reports are filed, OHIC may not be aware that a new carrier has entered, or is attempting to enter, the small employer market.

Carriers typically review the laws and regulations specific to a market of interest prior to entering a new state. There is nothing in the current small employer language to require a carrier to notify OHIC of its intentions. We believe that a requirement to notify OHIC prior to the time a carrier's first quotation is issued to a Rhode Island small employer would help ensure that new entrants operate within the requirements of the legislation and accompanying Regulations.

11. Definition of Small Employer and Affiliates

The carriers requested clarifying language with regard to two elements of the definition of small employer. The first request is for a clearer definition of “affiliated group.” The second request is for a carrier to have the ability to consider the employees of an entity in Rhode Island that is affiliated with an out-of-state group to be considered a Rhode Island small group if it otherwise meets the Rhode Island definition of “small employer.”

We do not feel strongly about either of these recommendations, but they seem reasonable. Enabling a carrier that is licensed to do business only in Rhode Island to write Rhode Island employees of a larger, multi-state group as a small employer will potentially increase the number of insured lives. A clearer definition of “affiliate” might also enable additional individuals to be eligible for health insurance.

F. Impacting the Cost of Care

We were specifically asked to consider how our findings might impact the issue of affordability as we developed our recommendations for the small employer market in Rhode Island. Market conduct and rating requirements primarily impact the way that the cost of health care is distributed among covered persons; they do not typically impact the underlying cost of care. During the course of our discussions and analyses, however, we have identified a number of steps that OHIC, employers, carriers and others can take to impact the cost of medical care itself.

Appendix E provides a brief look at some of the factors influencing the cost of health care in Rhode Island. We would like to take this opportunity to note some of the ideas for impacting the cost of health care that have come up during the course of our examinations.

1. Medical Management

We recommend that OHIC work with carriers to improve the medical management programs provided to members of small employer groups.

The first step in this effort is for OHIC to obtain from each carrier a detailed description of all of its medical management programs.³⁷ Carriers use different names to describe programs, but we would suggest that OHIC obtain information detailing, at a minimum:

- wellness and prevention programs and coverage;
- identifying and managing potential and actual high cost cases;
- management of pharmacy, laboratory, and radiology cost and utilization;
- management of individuals who consistently use the emergency room;
- end of life care;
- pay for performance programs and other initiatives to encourage providers in the provision of cost effective, quality care; and
- disease management programs.

Program descriptions accompanied by program penetration in the small employer population and cost/benefit information (including a description of the methodology used to obtain this data) about each program will enable OHIC to determine the strengths and weaknesses of each carrier's care management programs.

We encourage OHIC to work with each carrier to develop specific improvement goals focused on the areas above needing improvement at each carrier, based on the information obtained in the reports. In particular, given the findings of the Cryan report³⁸, we recommend that OHIC pay particular attention to carrier efforts in managing high cost cases and inappropriate emergency room utilization.

³⁷ We note that OHIC has requested and received a report on affordability initiatives from BCBSRI . This report was requested during the review of rates for Plan 65.

³⁸ See Appendix E.

2. Utilization Management

Both major carriers expressed concerns with the limits imposed on potential medical management and utilization review programs given the existing Rhode Island utilization review legislation. One carrier also expressed concern about the difficulty of sanctioning inefficient providers and/or denying coverage for care deemed medically unnecessary.

We have not studied this legislation, but to the extent that carriers believe it significantly infringes on their ability to appropriately manage care and/or their provider networks, we recommend that OHIC attempt to resolve concerns while ensuring that appropriate consumer protections and balance are maintained. We understand that a task force is looking into this matter, and we encourage OHIC to participate in these discussions. The cost effectiveness of all health insurance coverage, not just that which is provided to small employers, may be impacted.

3. Generic Substitution

During the course of our study it came to our attention that Rhode Island law allows patients to override a physician's determination that a pharmacist may substitute a generic drug in place of a brand name drug. Prescription drug cost and utilization are a major component of both the absolute level of cost and the increase in the costs of health care. The ability of patients to over-ride mandatory generic substitution in the absence of a physician's requirement to dispense a brand drug leads to unnecessary cost.

Withstanding the onslaught of advertising for brand name pharmaceuticals is difficult enough for physicians; advertising is now aimed at consumers because it is very effective. Purchase of brand name medications absent a physician's requirement is an inefficient use of health care resources. We therefore recommend that OHIC pursue with the correct Rhode Island authorities the potential for eliminating the ability for patient's to override the physician's determination re: the appropriateness of dispensing a generic medication.

4. Assistance with RlteShare

The RlteShare program provides subsidies toward the employee's share of the health insurance premium for working families at a qualifying income level. Families who might not otherwise be able to afford it are thus able to participate in employer-sponsored health insurance.

RlteShare is a national model for this type of premium assistance program. However, the availability of additional data would lead to improvement in two areas—the ability to determine whether individuals and/or families are eligible for assistance and the ability to know when individuals or families currently participating in the program leave employment and thus are no longer eligible for premium assistance payments.

We recommend that carriers be required to provide the Rhode Island Department of Human Services (DHS), which administers RlteShare, with more timely information about all small employers that offer health coverage, and that the information provided include the specific plan code for the benefit plan offered by each employer. This information will enable RlteShare to determine whether or not it is cost effective for the state to assist a family at a particular employer. We also recommend that carriers be required to notify DHS when RlteShare participating employees are terminated from small employer coverage, so that DHS is not paying premium assistance for persons who are no longer eligible.

This additional data will help add people to the insurance roles in a cost-effective fashion for the state.

5. Continuation of Coverage

Employers with twenty or more employees are required by federal law to allow an employee who leaves employment to remain on the employer's health insurance coverage. This provision is known as COBRA continuation. The length of time one can remain in the employer's plan is dependent on the reason for leaving employment. The insurer can charge up to 102% of the cost of coverage, in order to cover additional administrative costs.

R.I.G.L. Chapter 27-19.1, Extended Medical Benefits, enables certain employees (or their dependents) who leave employment to continue the benefit plan of the employer's health insurance coverage on a direct basis with the carrier. However, permissible reasons for maintaining the benefit plan differ from the federal COBRA requirements. Most notably, an individual who voluntarily leaves employment is not eligible for Rhode Island extended medical benefits.

As a means of potentially increasing the number of insured persons in Rhode Island, we recommend that permissible reasons for eligibility for Rhode Island extended medical benefits be changed to add all COBRA eligibility reasons. This will provide additional protection to employees of employers who are not covered by COBRA.

Conclusion: Achievement of the Purposes of the Act

As part of its oversight of the small employer group health insurance market, OHIC initiated this effort and thereby created an opportunity to improve accessibility and affordability, which has the potential to reverse the negative enrollment trends in the Rhode Island Small Employer Group Health Insurance market. While our findings and policy recommendations point out that there is much work to be done to achieve all the goals set in motion through the promulgation of the *Small Employer Insurance Availability Act*, we believe OHIC will find the actionable recommendations will move the carriers toward a level playing field, increase enrollment, stabilize risk pools and moderate costs over the long term, thereby enhancing the market for all stakeholders.

APPENDICES

Appendix A: Market Conduct Examination Recommendations for Blue Cross Blue Shield of Rhode Island

1. It is recommended that Blue Cross investigate whether intermediaries are adding a monthly fee to the premiums charged by Blue Cross and, if so, require that intermediaries cease the practice.
2. It is recommended that Blue Cross create a listing that indicates for each small employer the amount of fees, if any, the small employer paid to intermediaries since October 1, 2001.
3. It is recommended that Blue Cross review its agreements with the intermediaries and determine if the fees described are received by the Chambers or the participating small employer. If Blue Cross determines that the payments are received by the Chambers, Blue Cross should determine if the receipt of such payments results in any benefit to the participating small employers. If the payments made by Blue Cross result in a benefit that accrues to the small employer it is recommended that Blue Cross determine the amounts paid for each such small employer since May 1, 2003.
4. It is recommended that Blue Cross establish a plan to periodically audit those third party entities that collect and remit premiums on behalf of Blue Cross.
5. It is recommended that Blue Cross include in its rate manual a description of the methodology used to allocate operating expenses to the lines of business.
6. It is recommended that Blue Cross include, as part of its Actuarial Certifications, statements from all persons on whom the actuary signing the Certification relied. These statements should include a description of information that the signing

actuary relied upon and that further indicates the accuracy and completeness of that information.

7. It is recommended that Blue Cross review its policies related to documentation of out-of-state employers and the treatment of employees of employers who go out of business.
8. It is recommended that Blue Cross amend its Sales Agreement to reflect actual practice with respect to the right of a small employer to terminate.
9. It is recommended that Blue Cross review its documentation (including electronic) to ensure that it includes groups of one eligible employee within the criteria for eligible small employer in all its marketing contexts and public communications.
10. It is recommended that Blue Cross modify the disclosure form to reflect its actual practice as it relates to the development of rates for individuals over age 65.
11. It is recommended that Blue Cross modify the disclosure form to reflect its actual practice as it relates to the calculation of the participation level.

Appendix B: Market Conduct Examination Recommendations for United HealthCare of New England and United HealthCare Insurance Company

1. It is recommended that United make the toll-free number required by Regulation 82(10)(C) adequately available to the small employer community by having it included in the local telephone directory and identified as a small employer health insurance contact number.
2. It is recommended that United revise its website content to include information regarding health care plans available for groups of from one to 50 employees in Rhode Island.
3. It is recommended that United include documentation supporting the development of its base rates in its rate manual, including description of the basis for its expense factors, pricing loss ratio, and experience basis for claims cost.
4. It is recommended that United document age/sex factors that reflect the actual demographics of each group as part of its renewal rating process. This is necessary in order to enable verification of rating accuracy and of compliance with the 4:1 rate compression requirement.
5. It is recommended that United limit its health status adjustments to an amount that is at maximum an amount equal to plus or minus ten percent from the age/sex adjusted community rate, subject to all other limitations imposed by R.I.G.L. § 27-50-5, and identify any groups that may have been charged premium rates more than ten percent higher than average rates.

**The Effectiveness of the Small Employer Health Insurance Availability Act in Promoting Rate Stability,
Product Availability, and Coverage Affordability**

6. It is recommended that United properly document age/sex factors on a group by group basis as part of its renewal cycle in order to be able to verify rating compliance.
7. It is recommended that United include in its rate manual a description of the calculation of its plan relativity factors.
8. It is recommended that United review its rate relativity factors for the statutory Standard and Economy plans to ensure that they appropriately reflect benefit differences only.
9. It is recommended that United include in its rate manual a description of the methodology used to allocate operating expenses to the Rhode Island small employer business and how such allocated expenses are reflected in small employer rates.
10. It is recommended that United's documentation supporting the actuarial certification include a description of the marketing materials, subscriber agreements, and employer contracts that were reviewed and by whom.
11. It is recommended that any statement from an individual on whom the certifying actuary relies for any aspect of the certification include a description of the work performed and an assessment of its accuracy and completeness.
12. It is recommended that the certifying actuary indicate, in conjunction with any instances of non-compliance, the nature of the non-compliance and the steps taken to correct non-compliance prospectively and retrospectively, as appropriate.
13. It is recommended that the certifying actuary include conclusions with respect to the review of the rating of new business cases in the actuarial certification.
14. It is recommended that United include, as part of its Actuarial Certifications, statements from all persons on whom the actuary signing the Certification relied. These statements should include a description of information that the signing

actuary relied upon and that further indicates the accuracy and completeness of that information.

15. It is recommended that United provide complete case files that include the data described on pages 60 and 61 of this report.
16. It is recommended that United include in its underwriting manual its underwriting policies with respect to renewals.
17. It is recommended that United maintain on a case by case basis renewal underwriting files that document the renewal underwriting process.
18. It is recommended that United collect, in conjunction with the renewal process, information that will allow it to administer the requirements of Regulation 82(3)(E).
19. It is recommended that United collect and maintain, in accordance with Regulation 82(6)(B)(2) waiver forms for every eligible employee and every eligible dependent who chooses not to enroll in the health plan.
20. It is recommended that United modify its pre-existing condition limitation so that it satisfies the requirements of R.I.G.L. § 27-50-7.
21. It is recommended that United develop and maintain a medical underwriting manual, as required by R.I.G.L. § 27-50-5(h) and Regulation 82(5).
22. It is recommended that United maintain a Financial Underwriting manual, as required by R.I.G.L. § 27-50-5(h) and Regulation 82(5).
23. United should review the circumstances of its complaint file 119156 as discussed on page 80 of this report and answer each of the questions with regard to the complaint that were asked on pages 79 and 80 of this report. To the extent corrective action is required with regard to that policyholder or others similarly situated, United should identify the corrective action needed.

**The Effectiveness of the Small Employer Health Insurance Availability Act in Promoting Rate Stability,
Product Availability, and Coverage Affordability**

24. It is recommended that United review its Joint Health and Life Employer Application to determine whether the overall cost and the mechanism of cost recovery for bonus payments are described properly.
25. It is recommended that United provide, as part of its proposal and renewal process, the disclosures required by R.I.G.L. § 27-50-5(g) in its application forms and in all renewal and proposal packages.
26. It is recommended that United include rates and descriptions of the Standard and Economy plans as options in all proposal and renewal packages, as required by R.I.G.L. § 27-50-7(b), Regulation 82(10)(A)(2) and Regulation 82(10)B).
27. It is recommended that United review its documentation (including electronic) to ensure that it includes groups of one eligible employee within the criteria for eligible small employer in all its marketing contexts and public communications.

Appendix C: Glossary

Adjusted Community Rate: the community rate with demographic adjustments allowed by Chapter 27-50 (age, gender, and health status.)

Adjusted Community Rating: A rate development methodology in which the community rate is adjusted by a limited and prescribed set of demographic characteristics or factors which are thought to influence the expected level of claims costs of a particular individual. Currently allowed “adjustments” in Rhode Island are age, sex, and health status. In Rhode Island, there is a limit to the size of the adjustment for health status, and an overall limit on the range of adjustments.

Adverse Selection: The propensity of buyers of insurance to act in their own self-interest. When given choices, the healthier individuals may buy the cheaper products, or opt out entirely, while the least healthy individuals or groups are likely to buy the most comprehensive coverage. This can result in imbalance among carriers and in additional cost for the market as a whole.

Age/gender adjustments: A factor developed by a carrier to account for the influence of age and gender on expected claims costs. Typically, the older an individual the more claims one can expect him/her to generate. With respect to gender, male and female claim costs change in a different pattern as people age. For example, females of child-bearing age generally use more services than males of the same age.

ASO: Administrative Services Only: Under such an arrangement the employer assumes responsibility for the actual benefit costs incurred by employees and dependents. Typically the employer will hire a third party (which may be an insurance carrier) to provide administrative services and network access. Typically, the employer will obtain “stop loss” insurance to reimburse the employer for costs in excess of specified limits.

Back-door Underwriting: Attempts to circumvent the accepted and documented underwriting procedures. Such steps are designed to have a favorable impact on the risk pool enrolled at a carrier. An example of back-door underwriting would be to require applicants to a Medicare Advantage product to enroll in person in a room which can be reached only by climbing two flights of stairs.

Base Rate: The base rate is the starting premium rate which is adjusted by plan factor and allowed demographic factors to produce the adjusted community rate.

Benefit Plan: The specific benefits covered by the product that the small employer purchases. The term benefit plan includes both the network of providers (e.g., hospital, physician), the services covered by the plan (e.g., radiology, laboratory, office visits) and the amounts that the patient pays for the specific service (deductibles, coinsurance, and co-payments). In this paper, benefit plan and product may be used interchangeably.

Broker: Rhode Island uses the term “producer” to refer to individuals who perform the functions of a broker: A person licensed as an insurance producer by the State of Rhode Island who assists individuals and employers with the purchase of health insurance. They represent the small employer, providing information and answering the employer’s questions about products offered by all carriers in the market. Typically, they receive a commission, paid by the insurance carrier. Both United and BCBSRI build this expense into the rates charged to all small groups.

Coinsurance: A percentage amount (usually the percent of a carrier’s allowed charge) that is not payable by the carrier and is instead the responsibility of the patient. Coinsurance is one type of cost-sharing.

Contract Type: Each employee purchases coverage for him/herself and potentially a number of dependents, e.g., children or a spouse. Chapter 27-50 requires that carriers offer four contract types in the small employer health insurance market. They are:

- Employee only
- Employee and child(ren)

- Employee and spouse
- Employee, spouse, and child(ren)

Without the specific statutory requirement, a carrier could offer different combinations. Examples of other combinations are:

- Two contract types—Employee only and Family, or
- Three contract types—individual, two person, and family.

Community Rating: A rating methodology that reflects the anticipated claim experience of the enrolled population and the benefit plan chosen. In full community rating, everyone with the same rate effective date and the same benefit plan and contract type pays the same rate. Under community rating, rates would not vary by sex, age, and health status.

One result of community rating, therefore, is that the young and healthy subsidize the older and sicker members of the risk pool. This is because the older and sicker members will most probably generate more medical expenses than younger and healthier individuals but still pay the same rate.

Copayment: A flat dollar amount payable by the patient to the health care provider (e.g., physician, pharmacist) at the time of a particular service. A copayment is one type of cost-sharing.

Cost Sharing: The component of a claims payment which is not covered by the carrier and is therefore the responsibility of the subscriber. Cost-sharing includes deductibles, coinsurance, and copayments.

Credibility: The degree to which a group's premium rates are based on the group's own claims experience. The largest groups are fully credible and the smallest groups are not credible, but are rated on manual or pooled rates. Intermediate size groups are given partial credibility, and are rated partly on manual rates and partly on their own experience.

Creditable Coverage: defined in §27-50-3.

Decline: An indication on the employee enrollment form or other carrier provided form that the employee and/or the employee's dependents are not enrolling in the health insurance plan, even though they do not have other coverage. See also "Waiver of Coverage."

Deductible: A flat dollar amount payable by the insured to providers of care prior to the start of insurance coverage. An insured may need to pay multiple providers for multiple services prior to satisfying the entire deductible. A deductible is one type of cost-sharing.

Dependent: family members of the employee (e.g., spouse, children). An eligible dependent is a dependent who can enroll in the health plan by virtue of the employee's eligibility.

Direct Business: Employer groups that are not represented by a producer. For direct business, the carrier's marketing representatives work directly with the employer.

Distribution Channel: the means by which information about health insurance products is provided to potential customers and policies are marketed and sold. The distribution channels can include producers, intermediaries, and salaried staff (i.e., Direct Business).

Employee Enrollment Form: The form filled out by or for each eligible employee who wishes to enroll him/her self and any eligible dependents in the health plan offered by the employer. It can provide space for an employee waiving or declining coverage, and collect individual medical information to support the development of a health status factor.

Enrollee: Every individual, whether the employee or a dependent of the employee, who is a member of the health insurance plan.

Experience Rating: A rate development methodology in which rates are based on a projection of the employers historical claim experience.. Most carriers require a minimum number of enrolled persons to rate a group solely on its own experience. Employer groups with fewer than 50 enrolled subscribers are considered to be too small to be rated solely on their own experience. For mid-size groups, carriers will frequently use a blend of the experience rate and the adjusted community rate (see Credibility).

4:1 Compression: R.I.G.L. § 27-50-5(a)(5) requires that the highest rate charged by a carrier for a specific contract type and benefit plan for a specific effective date be no greater than 4 times the lowest rate charged by that carrier.

Health Status Factor: A factor developed by each carrier based on an estimate of the expected claims experience of a group. The Act limits the health status adjustment to plus or minus ten percent of the base rate. Thus, one would expect health status factors to range from 0.90 to 1.10.

HMO: Health Maintenance Organization

HMP: Abbreviation used by United to designate a point of service plan sold by its HMO, United HealthCare of New England.

Intermediary: An independent organization under contract to an insurance carrier to perform various administrative functions such as billing, collecting premium, and enrolling members. In addition, an intermediary may be licensed to sell a carrier's insurance products. BCBSRI contracts with intermediaries to fulfill the list of services described here. United does not contract with intermediaries to perform administrative functions , but does treat them like any other producer to sell United benefit plans and pays them commissions.

Late Entrant or Late Enrollee: An individual who joins the employer's health insurance coverage after the enrollment period during which the individual is initially entitled to enroll. The Act includes specific instances for which an otherwise "late enrollee" is not considered to be such.

Medical Underwriting: A process used to analyze an individual's or small employer group's health status and assign a health status factor to the group. The basis for this process is information provided by the individual, the employer, or from an analysis of historical claims experience.

Member: Each person covered under an insurance contract. The subscriber (the employee who is enrolled in the health plan) is a member, as are each of a subscriber's dependents.

Minimum Participation Level: A carrier may specify that a minimum number of eligible employees must participate in the health plan. The Act states that currently a carrier cannot require a minimum participation level that is greater than 75% of eligible employees who do not have other coverage

PCPM: Abbreviation for per contract per month

PMPM: Abbreviation for per member per month

POS: Abbreviation for a point of service plan.

PPO: Abbreviation for a preferred provider organization.

Pool I: The Direct Pay population which has not passed medical underwriting. The rates for this population are set at approximately the maximum level of Pool II rates and are not age or gender rated.

Pool II: The Direct Pay population which has passed medical underwriting. The rates for this population are age and gender rated.

Pre-Existing Condition: The Act defines this as a condition "for which medical advice, diagnosis, care, or treatment was recommended or received during the six (6) months immediately preceding the enrollment date of the coverage," unless the person had prior creditable coverage continuous to a date not more than ninety days prior to the enrollment date of the new coverage.

Producer: An individual licensed to do business by the State of Rhode Island to sell, solicit, or negotiate the purchase of insurance. Brokers are sometimes known as producers or agents.

Rate Manual: A compilation of all the data, processes, policies and procedures used to develop health insurance rates, including the formulas and factors used to rate individual groups to assure actuarially based and consistent rating of all small employer groups.

Renewal business: A group which has already had coverage for at least one year.

Risk Pool: The group of people who are covered in a particular subset of business and whose claim experience is combined for the purpose of developing rates. For example, the small employer risk pool is composed of all enrollees in small employer groups.

Subscriber: The subscriber is the term given to the employee who enrolls in coverage. The number of subscribers is thus the same as the number of total subscriber contracts.

Tier: The demographic composition of each insurance contract. Chapter 27-50 requires that the small employer carrier rate small employer business using four different contract tiers—employee; employee and child(ren); employee and spouse; employee, spouse, and child(ren).

Underwriting: the processes used to determine:

- whether or not an employer group is eligible for a small employer health plan,
- the eligibility of each individual within that group,
- whether or not the group meets the carrier's participation and contribution requirements, and
- the health status of either the members or the overall group.

Medical underwriting is a component of the overall underwriting process.

Waiver: An indication on the employee enrollment form that the employee and/or the employee's dependents are not enrolling in the health insurance plan due to coverage under another health plan. See "Waiver of Coverage."

Waiver of Coverage: A section on the enrollment form or separate form that allows the employee to indicate that he/she declines coverage under the health plan. The form provides for coverage to be declined due to the existence of other coverage (which is called a waiver in this report) or despite having no other coverage at the time (which is called a decline or a declination in this report.)

Appendix D: Producer Survey

Questions for Producers

Intro: Commissioner Koller suggested we speak with you about small employer health insurance. We're in the process of completing market conduct examinations and analyzing the information in order to develop policy recommendations. We'd appreciate your thoughts about a number of issues.

1. What percent of your business is small employer health insurance?
2. Do you see a difference in behavior between smaller (e.g., less than 10) and larger (e.g., greater than 25) groups within the small employer block? If yes, what is that difference?
3. What do you see as the key factors influencing the cost of small employer coverage?
4. What do you see as the key factors influencing small employers re: carrier and/or product to go with?
5. We've heard it suggested that having additional carriers enter the market would lower rates. Do you think this is correct? Why or why not? How do you suggest we encourage additional carriers to enter the market?
6. Have you come across any instances of other carriers entering the market with respect to the self-employed? What has their impact been thus far?
7. What do you think might bring more small employers into the market?
8. What do you think the reaction would be if carriers offered fewer products, and transferred individuals into those products?

**The Effectiveness of the Small Employer Health Insurance Availability Act in Promoting Rate Stability,
Product Availability, and Coverage Affordability**

9. What do you think the reaction would be if the rate band were widened?
Lessened? Would new, younger people enter? Would current, older enrollees leave?
10. What would you change about the current legislation or regulations? Why?
11. The DBR just issued a bulletin re: alerting clients to the fact that producers receive a commission. Do you have any concerns re: increasing the transparency of distribution costs?
12. What do you see as the ideal role for the state in small employer health coverage?

Appendix E: Cost Drivers

As part of the small employer review, we were asked to consider the major cost drivers in the Rhode Island health care system and to provide a brief explanation of those drivers in this report. A number of producers mentioned high utilization levels as the key reason for high insurance rates in Rhode Island. A look at some research of the Rhode Island marketplace confirms that utilization levels are indeed an issue.

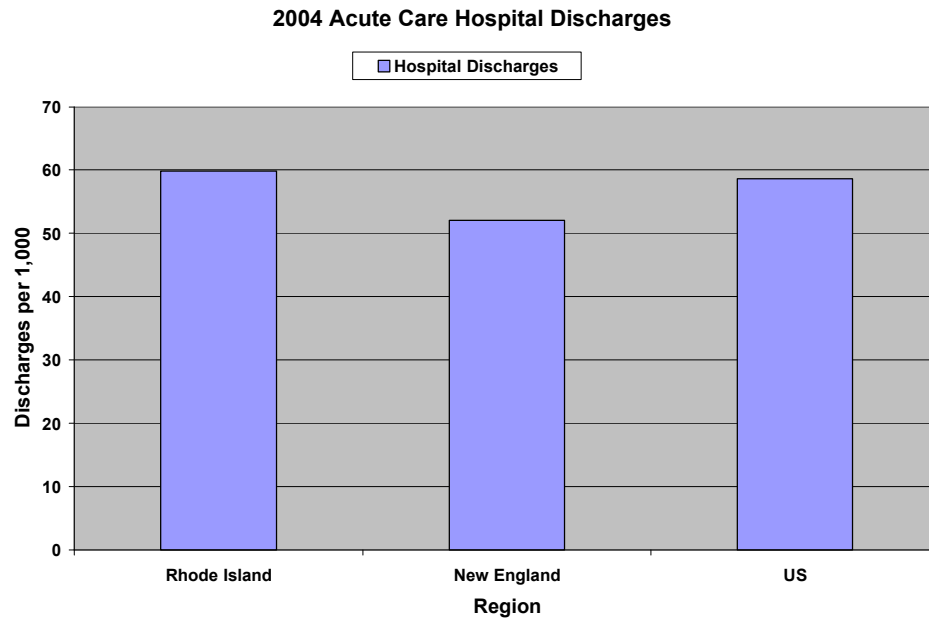
Hospital Utilization

A report by the Rhode Island Department of Health looked at the performance of Rhode Island carriers.³⁹ The data in this report are for all sized groups insured by BCBSRI (and Blue CHiP, which was a separate entity in 2004) as well as both United HealthCare of New England and United Healthcare Insurance Company. Data for Rhode Island residents covered by Blue Cross Blue Shield of Massachusetts are included as well. While the data are for all enrollees, not just those of small employer groups, there is no reason to assume that the overall relationships vary for small employer enrollees.

The rate of hospital discharges reported in this report reveals that Rhode Island, in 2004, saw a 15% higher discharge rate than the rest of New England.

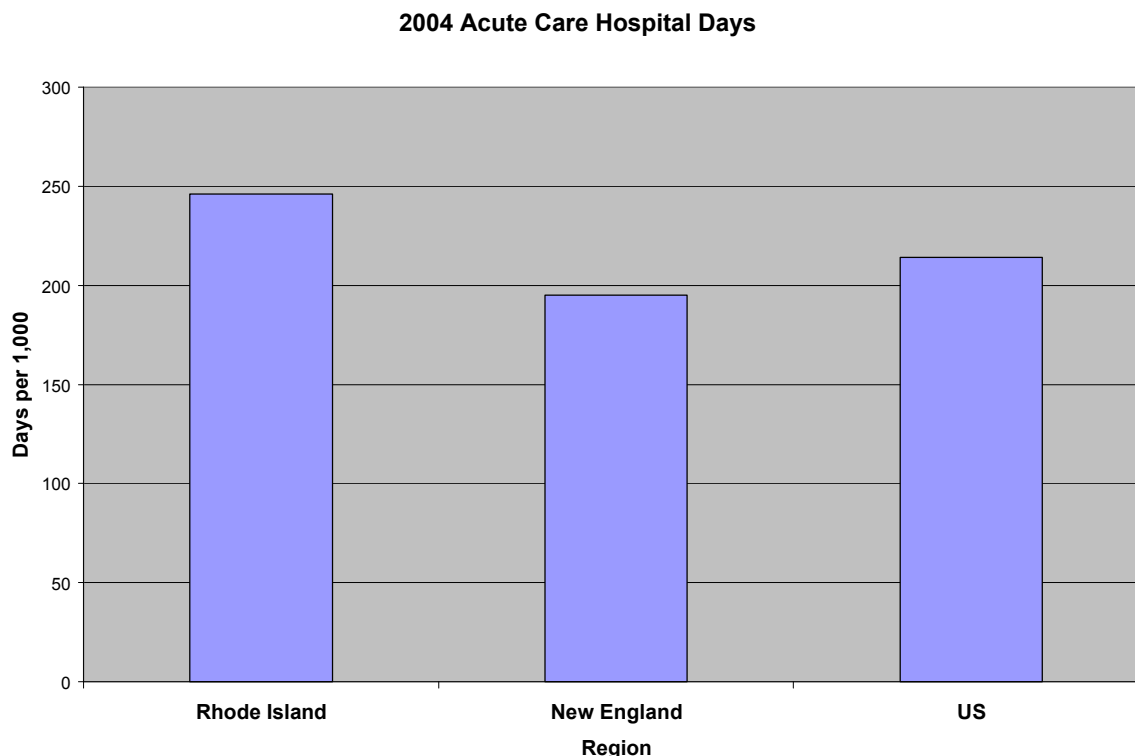
³⁹ Cryan, Bruce, MBA, MA, RI Commercial Health Plans' Performance Report (2004), Rhode Island Department of Health, Center for Health Data & Analysis, December, 2005. We will refer to this as the Cryan report going forward.

**The Effectiveness of the Small Employer Health Insurance Availability Act in Promoting Rate Stability,
Product Availability, and Coverage Affordability**



With respect to hospital days per 1,000, Rhode Island was at 246 acute care days per thousand in 2004, compared to 195 days per thousand for New England. Rhode Island utilization was thus 26% higher than the New England rate.

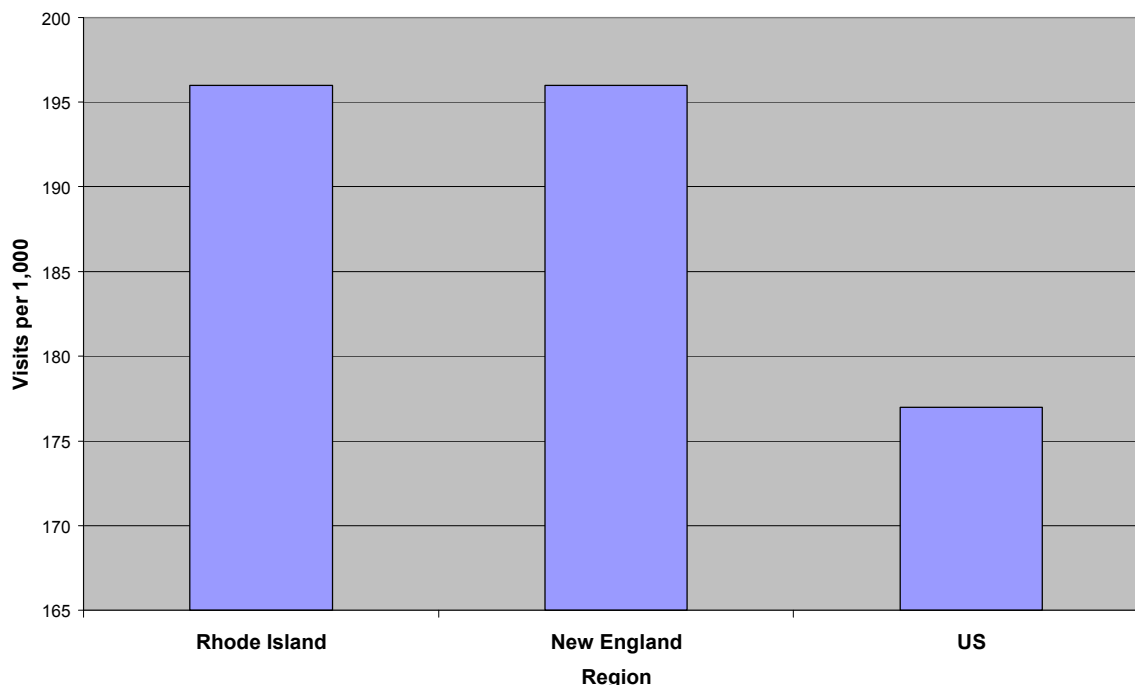
**The Effectiveness of the Small Employer Health Insurance Availability Act in Promoting Rate Stability,
Product Availability, and Coverage Affordability**



Using a rough estimate of \$1,500 for the cost of a hospital day at the end of a stay, and reported commercial enrollment of nearly 380,000, we estimate that Rhode Island insurers would have saved approximately \$18 million dollars in 2004 if RI hospital utilization were at US levels, and just over \$29 million if hospital days were at the New England level. (This estimate assumes that hospital payments are made on a per day basis. If hospitals are paid based on case rates, the estimated value saved might be quite different.)

The Cryan report also looked at the utilization of emergency departments. Here both Rhode Island and New England utilization are much higher than that of the US as a whole.

2004 Emergency Department Visits



Another source of emergency department utilization is the SHAPE Study.⁴⁰ The SHAPE study, sponsored by BCBSRI, is geared to understanding existing capacity in the health care system in Rhode Island and assessing the need for future health system resources. This ongoing study was conducted by Booz Allen Hamilton and RAND.

In 2002, when this first study from SHAPE was published, they found that “Rhode Island emergency department current utilization rates exceed US and Northeast averages by 4% and 9%, respectively.”⁴¹ While these figures are slightly different from the results depicted in the chart above, both sources agree that Rhode Island emergency room utilization is above the US average.

The SHAPE study also found that “Rhode Islanders visit their physicians 43% more often than US averages and 23% more than the Northeast region.”⁴² As the report points

⁴⁰ The Shape Study, Shaping the Future of Healthcare in Rhode Island, November 18, 2002.

⁴¹ Ibid, p. 7

⁴² Ibid, p. 7

out, “routine visits to a primary care physician (i.e., general internist, general pediatrician, general/family practitioner), and general OB/GYN are considered desirable results.”⁴³

Also of interest is the SHAPE study finding with respect to Magnetic Resonance Imaging (MRI) capacity. In 2002, they estimated that, as of 2006, 39% of capacity will be used when both hospital-based and free-standing MRIs are considered.⁴⁴ And, while the Certificate of Need program provides some control over hospital-based technology purchases (depending on the cost of the equipment), it appears that there is no such control of physician office-based equipment purchases. Indeed, during the course of discussions of medical management programs one carrier’s staff commented about the proliferation of MRIs in offices in the state.

Unfortunately, it is an accepted truism in health care policy—capacity creates demand. To the extent that physicians and hospitals have equipment which is not being used and thus not generating revenue to pay for the costs and upkeep of that equipment, we can expect demand to increase.

Indeed, a later SHAPE report determined that diagnostic imaging is one of five services (cardiac surgery, interventional cardiology, urology, and orthopedics are the others) where Rhode Island hospitals “lag other comparable institutions in terms of technology adoption.”⁴⁵ We would not be surprised, therefore, if the projection for 2006 in the SHAPE study for MRI usage was actually low. Of course, technology changes rapidly in this area, and new and better uses for MRIs as well as new and improved versions of the equipment, and new imaging techniques, all have an impact on the use of imaging. The point is the same, however—capacity creates its own demand.

It helps to get a sense of the magnitude of the costs associated with potentially unnecessary imaging. A Medical Director at BCBSRI mentioned that if every primary

⁴³ Ibid, p. 37

⁴⁴ Ibid., p. 43

⁴⁵ SHAPE II Facility Capacity Study, Executive Summary, Booz, Allen, Hamilton, Providence, RI, February 2005, Page 19

care physician ordered two less MRIs and two less CT scans per year, and every specialist ordered 1 less MRI and 1 less CT per year, BCBSRI would save \$4.1 million that year.

During our producer survey, multiple producers mentioned the age of the small employer enrollees as a reason for the high cost of health care. Unfortunately, we were unable to verify this due to the lack of accurate age data from both carriers. Generally, however, older individuals do use more health services than younger ones.

The publicly available data we have reviewed which focuses on the utilization of specific services—hospital days, emergency room usage, office visits—demonstrates that utilization is higher for these services in Rhode Island than in the country as a whole, and frequently than in New England. Having OHIC obtain baseline information about the medical management programs available to small employer groups will be crucial to the development of improvement goals, some of which may be geared to addressing the appropriateness of the utilization levels described here.